# Advancing Million Hearts®:
# AHA and Heart Disease and Stroke Prevention Partners Working Together in Washington

*August 10, 2017*
*Meeting Summary*

**Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in Washington a**

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## Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in Washington

On Aug. 10, 2017, 62 representatives from 37 Washington-based health organizations devoted to reducing the prevalence of heart disease met with the American Heart Association in Seattle to advance the mission of the Million Hearts® campaign.

The partner organizations collaborated on ways to align their individual efforts to better meet the Million Hearts® goal of preventing a million heart attacks and strokes over the next five years.

Representatives from two partners – Qualis Health, a national leading health management organization, and the Washington State Department of Health – made presentations on agency programs and resources that align with Million Hearts®.

Participants then separated into breakout groups to discuss and establish action plans around four priority areas:

- Hypertension control
- Role of community health workers
- Worksite wellness
- Public health policy

The day's worth of discussions helped participants expand their knowledge of evidence- based programs, collaboration strategies, tools and resources that they can then connect with their own programs and initiatives to help support and advance the Million Hearts® campaign.

Feedback from the meeting reflected the depth and value of information yielded from discussions. One participant said the meeting provided the first, formal overview of the Million Hearts® campaign. Another described the usefulness of having a list of partners and their contact information to help facilitate future meetings and collaborations.

"Thank you to everyone who is sitting around the table for taking the time out of your day, for sharing your knowledge, for putting together your presentations," one participant wrote. "This is a great outpouring and reminds me that there other colleagues who are working on hypertension control – my favorite organ in the body is the heart."


# Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in Washington

THURSDAY, AUGUST 10, 2017
8:30 AM - 3:00 PM PST

*Seattle Airport Marriott Hotel*
*3201 South 176th St.*
*Seattle, Washington 98188*

# MEETING PURPOSE:

Connecting staff from AHA Affiliates, state health departments and other state and local heart disease and stroke prevention partners to establish and engage in meaningful relationships around Million Hearts® efforts.

# MEETING OBJECTIVES:

At the end of the meeting, participants will be able to:

1) Identify Million Hearts® focused activities for 2017
2) Recognize Million Hearts® evidence-based and practice-based CVD prevention strategies and approaches
3) List partner programs and resources that align with Million Hearts®
4) Identify programs efforts that align and ways to work together
5) Create plan for follow-up to increase engagement
6) Recognize key contacts within heart disease and stroke prevention

# MEETING OUTCOMES

Attendees will have expanded their knowledge of evidence based programs, collaboration strategies, tools, resources and connections to align programs and new initiatives that support Million Hearts®.

# AGENDA

8:30 AM **CONTINENTAL BREAKFAST AND PARTNER NETWORKING**

9:00 AM **WELCOME AND OVERVIEW OF THE DAY**
Julie Harvill
*Operations Manager, Million Hearts® Collaboration*

Pama Joyner
*Director, Office of Healthy and Safe Communities, Prevention and Community Health, Washington State Department of Health*

**INTRODUCTIONS**
John Bartkus
*Pensivia*

In one sentence, what excites you about your role in heart disease and stroke prevention?

9:30 AM **MILLION HEARTS® 2022**
Robin Rinker, MPH, CHES,
*Health Communications Specialist, Division for Heart Disease and Stroke Prevention, Centers for Disease Control and Prevention*

- Million Hearts® Accomplishments
- What must happen to prevent?
- 2017 Focus

**Q AND A / GROUP INTERACTION**

10:15 AM **BREAK**

10:30 AM **WASHINGTON STATE HEALTH DEPARTMENT PROGRAMS AND RESOURCES THAT ALIGN WITH MILLION HEARTS®**
Cheryl Farmer, MD
*Manager, Heart Disease, Stroke, and Diabetes Prevention Program Community-Based Prevention Section, Washington State Department of Health*

Susan S. Buell
*Association Director of Adult Healthy Lifestyles and Chronic Disease YMCA of Pierce and Kitsap Counties*

**Q AND A / GROUP INTERACTION**

11:00 AM **QUALIS HEALTH PROGRAMS AND RESOURCES THAT ALIGN WITH MILLION HEARTS®**
Jeff Sobotka, PMP, MBA, CPHIMS, CHP
*Quality Improvement Consultant, Practice Coach, Qualis Health*, *Healthy Hearts Northwest Project*

**Q AND A / GROUP DISCUSSION**

11:15 AM **AHA/ASA PROGRAMS AND RESOURCES THAT ALIGN WITH MILLION HEARTS®**
Western States Affiliate Lindsay Hovind
*Senior Director, Government Relations*

Elaine Kitamura
*Regional Director, Multicultural Initiatives*

Kristen VanWart
*Sr. Community Health Director, Field Operations/Development*

Elizabeth Peterson
*Regional Director, Quality & Systems Improvement*

**Q AND A**

11:30 AM **CATERED LUNCH**

12:30 PM **AFTERNOON BREAKOUTS/FACILITATED DISCUSSIONS**
John Bartkus

Group 1. Hypertension Control
Group 2. Role of community health workers and community based organizations in addressing CVD
Group 3. Worksite Wellness
Group 4. Public Health Policy - Tobacco and Pharmacist

**WAYS TO WORK TOGETHER AND NEXT INTERACTIONS**
John Bartkus

- Plan for follow-up to increase engagement
- Key contacts within heart disease and stroke prevention with state

2:45 PM **EVALUATION**
Whitney Garney

3:00 PM **WRAP UP / ADJOURN**
April Wallace

**REGISTRANTS AS OF AUGUST 7, 2017**

*American Diabetes Association ■ An Ounce of Prevention ■ Center for MultiCultural Health ■ Chelan-Douglas Health District ■ Grant County Health District ■ Inland Northwest Health Services ■ King County Promotores Network ■ Million Hearts Collaboration, AHA ■ National Association of Chronic Disease Directors ■ National Forum for Heart Disease & Stroke Prevention ■ Pensivia ■ People for People ■ Public Health Seattle & King County ■ Qualis Health ■ Quality Food Centers (QFC) Pharmacy ■ Skagit Regional Health ■ Spokane Regional Health District ■ Swedish Medical Group ■ Tacoma Pierce County Health Department ■ Texas A&M University ■ "US Department of Health & Human Services (HHS) Region 10" ■ University of Washington ■ Washington Center for Nursing ■ Washington Office of the Insurance Commissioner ■ Washington State Department of Health ■ Washington State Department of Social and Health Services, Aging and Long-Term Support ■ Washington State Health Care Authority ■ Washington State Pharmacy Association (WSPA) ■ Washington State University ■ YMCA of Pierce and Kitsap Counties ■ Patient Centered Outcomes Research Institute (PCORI) ■ Kaiser Senior Caucus*

**Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in Washington**
**Thursday, August 10, 2017**
**Seattle Airport Marriott Hotel**

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**Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention**
**Partners Working Together in Washington**
**August 10, 2017**

## Meeting Summary

Washington has a strong group of dedicated partners who recognize the need to align their work to better meet their ultimate vision. Several major themes emerged during the meeting that address four priority action areas:

- Hypertension Control
- Community Health Workers
- Worksite Wellness
- Public Health Policy

**Themes:**

- What resources are already available to help providers address cardiovascular health and hypertension specifically?
- How do we leverage policy opportunities around priority areas such as cardiac rehab and tobacco control?
- How do we address priority populations and the diversity of cultures and languages in our state?
- How do we provide resources and support for non-physician team members such as pharmacists and community health workers?

**What was the greatest value of being at the meeting:**

"I appreciate seeing the MH 2022 goals- they are simple and something to keep in our minds to include in our work. Something for all of us to consider-what if we all committed to doing just one thing to address hypertension?"

"I really like having the list of all of the participants with emails and phone numbers so that we can all work together."

"Thank you to everyone who is sitting around the table for taking the time out of your day, for sharing your knowledge, for putting together your presentations. This is a great outpouring and reminds me that there other colleagues who are working on hypertension control – my favorite organ in the body is the heart."

**Action Areas Workplans:**

Groups were asked to report out on the following areas:

- **WHAT TO FOCUS ON**
  - **CURRENT STATE / CONTEXT (Where are we now?)**
    - Sharing - What are each of us/organizations focusing on in this space?
    - What has been successful (strategies and practices)?
    - What are the key challenges?
    - What are the issues we're seeking to address?
  - **CULTIVATING COLLABORATION / ALIGNMENT / OBJECTIVES**
    - What do we choose to solve/focus on?
    - In which areas can we work together? How? What would this look like?
    - What objectives do we seek to accomplish?
- **HOW TO GET IT DONE**
    - **DELIVERABLES / ACTIONS**
      What are specific deliverables?
    - What actions/tasks need to be carried out in order to complete each Deliverable?
  - **SUSTAINABILITY / MOMENTUM**
    - How does this group keep the momentum going/carry forward effort to action and results?
    - When do we next meet?

| HYPERTENSION CONTROL | | | | |
|---|---|---|---|---|
| Participants | | | | |
| Kathleen Nelson<br>Madelyn Carlson | Marlo Holloway<br>Yushi Li | Emily Fleury | Maura Carroll | Ka'imi Sinclair |
| *Discussion Leads:* Cheryl Farmer<br>Elaine Kitamura<br>Jeff Sobotka | | *Flip Chart Notes:* Feven Gurmu | *Notetaker:* Miriam Patanian | |

**Topic Areas:**
Check.Change.Control, Target BP
Self-Monitoring of blood pressure,
Proper blood pressure techniques;
Data and Evaluation from Healthy Hearts, Qualis Health

**OVERVIEW**

Heart disease is the leading cause of death in the United States. Healthy Hearts Northwest has been established to give primary care practices in Idaho, Oregon and Washington the support they need to help patients live healthier and longer.

The Agency for Healthcare Research and Quality (AHRQ) has funded the MacColl Center for Health Care Innovation at Group Health Research Institute to conduct a three-year project that helps primary care practices improve their patients' cardiovascular health—while also building capacity for quality improvement. Healthy Hearts Northwest is led by the MacColl Center with its partners, Qualis Health, the Oregon Rural Practice Research Network and the Institute of Translational Health Sciences at the University of Washington. Healthy Hearts Northwest is a cooperative of AHRQ's EvidenceNOW initiative to advance heart health in primary care.

**Practice Support**

Qualis Health provides practice support to small and medium sized practices in Idaho and Washington. Practices that participate in Healthy Hearts Northwest receive the following benefits:
15 months of practice support
Technical assistance for health information technology
Coaching in quality improvement (QI)
Opportunities to participate in trainings to build QI competencies

**Improve Heart Health for Patients**

Participating practices improve patients' cardiovascular outcomes through:

- Aspirin
- Blood pressure management
- Cholesterol management
- Smoking cessation

**Strategic Experts**

Healthy Hearts Northwest is led by organizations with 20 years of experience working with primary care practices:
The MacColl Center for Health Call Innovation at Group Health Research Institute
The Oregon Rural Practice Research Network (ORPRN) at the Oregon Health & Science University (OHSU)
Qualis Health
The Institute of Translational Health Sciences

**DISCUSSION**

**The WHAT**

- **What are the issues your organization is seeking to address?**
  - How do we support communication to providers, those who support the providers, to connect this information to the communities, share what resources exist, etc.
  - Providence Clinic - only have a cardiologist for people who have hypertension; primary care physicians don't have the time to reduce hypertension
  - Some primary care physicians say they can't refer to DPP
  - There are no programs in Eastern WA to do awareness of hypertension or heart disease. No coalition.
  - Could we address the clinic workflow to determine if there can be changes in the primary care practice?
  - Medication management/patient adherence. Can we address motivational interviewing?
  - Health IT - is there a way a provider could know within their EHR - a collaborative practice agreement
  - Most pharmacies are addressing hypertension, statin use for people with diabetes. They know their prescription fill rates. Can be enrolled in adherence monitoring program (those who have been flagged to be nonadherent. The challenge, pharmacists are so busy, how can they truly counsel their patients?
- **What are the key challenges?**
  - Very limited budget
  - Data sharing between EHR and pharmacy data systems

**What do we choose to focus on?**

- Expanding resources
- Could we model a hypertension program after DPP?
- Qualis has a number of resources available
- Conduct a series of assessments of primary care practices to identify where they need the most support
  - Resource assessment of what resources are currently available?
  - Needs assessment of what the needs of providers are
  - Coverage assessment - What does Medicare and Medicaid cover currently for hypertension control?
  - What are payers incentivizing patients and providers for related to hypertension control?

**The HOW**

- **How do we accomplish this? What specific actions or tasks need to be carried out in order to complete each step?**
  - UW HPRC developed a document related to hypertension evidence-base.
  - Needs assessment - Qualis is talking with primary care associations and could ask questions about what the providers need. Emily Fleury to ask Spokane Regional Health District to come up with the questions
  - Social media messaging - state will share
  - Coverage assessment - Emily Fleury, (end of September), Jenny Arnold (Yushi to connect)

**Deliverable - Assessment of available resources, workforce needs and payer coverage— for hypertension control.**

| Action | Who | By When |
|---|---|---|
| Resource assessment to identify what resources are currently available to support healthcare providers in addressing hypertension control. UW HPRC prepared a '16 report that may address this need. | C. Farmer will share the document with the HTN workgroup | August 11 |
| Coverage assessment to identify what Medicare and Medicaid cover currently for hypertension control | E. Fleury will connect with Jenny Arnold | September 30 |
| Needs assessment to better understand what providers need to better manage their patient population with hypertension – Qualis is already talking with primary care associations across the state about the Quality Payment Program, and could consider adding a couple of questions of these provider groups. | E. Fleury to ask Spokane Regional Health District to come up with questions for Qualis | February 2018? |

## ROLE OF COMMUNITY HEALTH WORKERS AND COMMUNITY BASED ORGANIZATIONS IN ADDRESSING CVD

| Participants | | | | |
|---|---|---|---|---|
| Kelsey Stefanik-Guizlo<br>LizBeth McNeth-Crowl | Jamie Hunter-Mitchell | Jim Sullivan | Cathy Meuret | Erika Parade |
| *Discussion Leads:* Marissa Floyd, Alexandro Pow Sang, Debbie Spink | *Flip Chart Notes:* Julia Schneider | | *Notetaker:* April Wallace | |

**Topic areas:**
What do CHW's do?
How do they do their job?
How do we support their need for low literacy education on cholesterol, blood pressure and nutrition?

**OVERVIEW**

The Community Preventive Services Task Force (CPSTF) recommends interventions that engage community health workers to prevent cardiovascular disease (CVD) among clients at increased risk. The Task Force finds strong evidence of effectiveness for interventions that engage community health workers in a team-based care model to improve blood pressure and cholesterol. They find sufficient evidence of effectiveness for interventions that engage community health workers for health education, and as outreach, enrollment, and information agents to increase self-reported health behaviors (physical activity, healthful eating habits, and smoking cessation) in clients at increased risk for CVD. Economic evidence indicates these interventions are cost-effective. A small number of studies suggest that engaging community health workers improves appropriate use of healthcare services and reduces morbidity and mortality related to CVD. When interventions engaging community health workers are implemented in minority or underserved communities, they can improve health, reduce health disparities, and enhance health equity.

Interventions that engage community health workers to prevent cardiovascular disease aim to reduce risk factors among those at higher risk by providing culturally appropriate education, offering social support and informal counseling, connecting people with services, and in some cases delivering health services such as blood pressure screening. Community health workers (including promotores de salud, community health representatives, community health advisors, and others) are frontline public health workers who serve as a bridge between underserved communities and healthcare systems. They typically are from or have a unique understanding of the community served. Community health workers often receive on-the-job training and work without professional titles. Organizations may hire paid community health workers or recruit volunteers.
https://www.thecommunityguide.org/findings/cardiovascular-disease-prevention-and-control-interventions-engaging-community-health
CDC

CHW resources:

- https://www.cdc.gov/dhdsp/pubs/chw-toolkit.htm
  - Everything you ever wanted to know about CHWs
  - Sodium fotonovela under 'Training and Education Resources'
- Might be interesting if they're talking policy https://www.cdc.gov/dhdsp/pubs/docs/SLFS-Summary-State-CHW-Laws.pdf
  - State Law Factsheet on what laws and regulations states have re: CHWs

**DISCUSSION**

**The WHAT**

- **What are the issues your organization is seeking to address?**
- **What has been successful (strategies and practices)?**
- **What are the key challenges?**

Department of Health- CHW training is a comprehensive 8 week program that focuses on the role of CHWs; communication skills, cultural competency; organizational skills; assessment of individual and community; behavioral health.

Department of Social and Health Services- 240 contracted nurses, 5 nursing programs. Interested in providing resources to the nurses; how to enhance the services they provide; interested in CHW training.

Seattle/King County- embedded CHW's in clinics; also placed them in homes as part of a SNAP-Ed pilot; PCORI project on asthma to look at triggers within the home and medication adherence. ACH project- using CHW's on heart disease, asthma, and diabetes. Group training to link these models together.

Spokane Regional Health District- 3rd year of project focused on SNAP-Ed. They also have 1422 funding. In home visits- education on nutrition and physical activity- has been very successful.

Skagit Regional Health- PATHWAYS project through ACH. Challenged with how to build CHWs into their programs. In hospitals, CHWs are working with highest risk patients.

Chelan-Douglas Health District- defining the role of CHWs, interested in supporting more structure and training of CHWs.

Patient-Centered Outcomes Institute (PCORI)- Support community resource managers. LEAN project with patients and project staff designed the project. Kaiser is going to expand this across the state. Challenges- EPIC, HIPAA, licensure. LINC- Learning to Integrate Neighborhoods to Clinical Care.

Qualis Health has a number of resources for CHWs to meet them where they are. They will train them and will work with organizations to tailor trainings to meet their needs. Also administer CDSME and pain program – they are a licensed provider. Contact- Jamie Hunter-Mitchell.

American Diabetes Association (ADA) is partnering with organizations that have CHWs on staff and communities with high burden of diabetes. Offers CE and resources and ambassador training. Contact- Kelsey Stefani- Guizlo.

2-1-1 has over 150 languages but is very underutilized. Contact – Tim Sullivan

**What do we choose to focus on?**

- **What would success look like for this work?**
- **What objectives do we seek to accomplish?**

Themes- Resources; Health Literacy; Recruitment/Retention

**Health Literacy-**

Language specific materials, infographics, videos
Health Literacy Conference in Baltimore in October

**Resources-**

Need resources in simple language that is appropriate for a 3rd grade reading level

Help the client know how to prepare for a clinic visit-how to get the most out of a visit.

- Prepare questions
- How to ask for clarification
- Prep physicians to better understand patients
- Choosingwisely.org

**CHW Recruitment/Retention-**
Work overload- self-care and burnout
CHW's overwhelmed due to low numbers
Cost of training for training for nursing assistants

**The HOW**

- **How do we accomplish this? What specific actions or tasks need to be carried out in order to complete each step?**
- **Who can we increase awareness of existing or new resources?**
- **How do we want to stay accountable to these plans?**

How do we partner on getting resources in simple language that is appropriate for a 3rd grade reading level?
The need for one-pager on addressing multiple risk factors and CVH conditions; addressing the whole person- something that can be translated to many languages.
Making resources more culturally appropriate-health literate

- Multiple Languages
- Colors and sounds
- Innovative videos

- Produce a document that provides simple visual that explains CVD and what contributes to it. Provide resources that:
  - Can be translated into different languages
  - Are mindful of cultural sensitivities

Support for CHWs Support CHW ongoing to convene and have dialogue to address concerns-need to know what is needed for support (DOH Contact)

- Monthly meeting/potluck to address concerns, regional meetings in addition to yearly CHW conference
- CNA's to take training to increase retention
- Regional conferences to get more sufficient feedback

**Deliverable -**
**Assessment of available resources, current workforce needs, and payer coverage—all related to hypertension control.**

| **Action** | **Who** | **By When** |
|---|---|---|
| Promote CHW trainings (ie. DOH training, Qualis, and American Diabetes Association) | DOH, Jamie Hunter-Mitchell, Kelsey Stefani-Guizlo | |
| Identify or develop one-pager on addressing multiple risk factors and CVH conditions; addressing the whole person- something that can be translated to many languages. | Collaboration with AHA? | |
| Host monthly meeting/potluck to address concerns; host regional meetings in addition to yearly CHW conference. | DOH; others? | |

## WORKSITE WELLNESS

| Participants | | | | |
|---|---|---|---|---|
| Lanae Caulfield | Susan Buell | Kathleen Randall | Pama Joyner | Tory Henderson |
| Aaron Huff | Marge Tully | | | |

| | | |
|---|---|---|
| *Discussion Leads:* Sara Eve Sarliker, Kristen VanWart | *Flip Chart Notes:* Sara Eve Sarliker | *Notetaker:* Julie Harvill, Mary Jo Garofoli |

**Topic areas:**

Learn worksite wellness needs and support for blood pressure devices, walking and exercise encouragement, healthy food choices and environmental changes.

**OVERVIEW:**

The coordinator for the Washington state facilities will share their work including a box with an automated blood pressure monitor that employees can use with educational resources and blood pressure tracker.

**Worksite Wellness at a Glance**

Helps employees take responsibility for lifestyle choices
Educates workforce about hazards and opportunities for wellness
Enhances employee productivity
Reduces absences and idleness
Reduces health care costs
Shifts health care paradigm from treatment to prevention

**For Employers**

Establish programs for exercise during the workday
Implement a no-smoking policy and provide resources for tobacco cessation
Allow flexible work schedules and telecommuting
Encourage personnel to take the stairs
Select worksites close to public transportation, walking trails, fitness facilities, and other amenities

**DISCUSSION**

**The WHAT**

- **What has been successful (strategies and practices)?**
  - Incentives to get initial participation
  - Emphasis on intrinsic motivation
  - Tapping into "why"
  - Culture of health
  - Variety
  - Don't mark workout as private – upper management encourages exercise
  - Incorporating feedback to adhere to values
  - Support senior leaders
- **What are the key challenges?**
  - Incentives work in the short term, but what about long-term solutions?
  - We don't focus on the "small steps"; we focus on outcome
  - Culture of health
  - Setting priorities – "work until done"
  - Managers / employees setting limits
  - Need management-level support
  - Demonstration of values needs to be constantly monitored

**What do we choose to focus on?**

Current focus

- Get $ back, 60% staff/spouse involved
- Association of WA Cities – incentives at the individual and employer level

We need to be more outward facing

- YMCA –
    - United Healthcare – incentives at the individual
    - Policies – policy adopted / gap / implementation
    - Employer engagement
- DOH
    - Dedicated wellness coordinator - DOH wants to be an employer of choice and to set an example
    - Volunteer team calendar
    - SmartHealth, DOH Wellness Program- Increase participation (what is current rate of participation?)
- AHA
    - Hoping to increase diversity
    - Behavior challenges – ie., "water"
    - Programs, including Check.Change.Control.
    - Switching our focus to overall health
    - "It's all about me" – earn time off
    - Fitness center discount
- Tacoma Pierce County
    - Works with small employers to offer wellness program support
    - Contact them – they offer small grants to help change policies
    - Walkability – there are city/county/Puget Sound plans to increase walkability and bikeability
    - Complete Streets
- Smoking Cessation
    - Smoke-free housing
    - Cessation classes through partnerships
    - HCA, DOH – smoking policy, cessation coverage
- **What objectives do we seek to accomplish?**
    - Sharing / creating resources
    - Shift messages to intrinsic motivation
    - What does the culture need to feel like?
    - Reducing stress in the workplace

**Resources**

- EAP – stress reduction
- AHA – Workplace Health Solutions, Food & Beverage toolkit
- DOH / State Agencies – Food & Beverage toolkit
- AWC – Well cities
- Washington Wellness – 7 to 8
- Ys – Worksite Connections
- Emphasizing intrinsic motivation
- Dedicated wellness coordinator & committee
- Senior leader support
- CDC Scorecard
- Managers on the Move – Engaging mid-level managers
- Practical Strategies for getting people involved in wellness
- What's working in WA State

**The HOW**

**How do we accomplish this? What specific actions/tasks need to be carried out to complete each step? Who can we increase awareness of existing or new resources? How do we want to stay accountable to these plans?**

**DELIVERABLE - Assessment of available resources, current workforce needs, and payer coverage—all related to hypertension control.**

| Action | Who | By When |
|---|---|---|
| | | |

## PUBLIC HEALTH POLICY – TOBACCO AND PHARMACIST

| Participants | | | | |
|---|---|---|---|---|
| Tory Henderson | Jim Freeburg | David Hudson | Renee Bouvion | Lena Hristiva |
| Kim Kelley | | | | |
| *Discussion Leads:* Lindsey Hovind, Jenny Arnold | *Flip Chart Notes:* Robin Rinker | *Notetaker:* Whitney Garner | | |

**Topic areas:**

Tobacco tax ballot initiative
Pharmacist scope of practice
Emergency Cardiac and Stroke Systems of Care

**OVERVIEW:**

Brief overview of how policy can be used as a tool to impact the ABCS (Lindsay with other presenters)

a. Systems, Policy and Environmental Change
   i. Scale of impact versus individual interventions
   ii. Achieve a change in the environment (ie, making it harder for kids to get tobacco), securing funding (ie, for paid media campaign or insurance reimbursements for treatment) and changing requirements of practitioners
b. Factors to consider when crafting policy
   i. History of the issue
   ii. Viability
   iii. Resources
c. Past examples
   i. Tobacco tax ballot initiative
   ii. Pharmacist scope of practice

d. Tobacco Sustainability Work Group Priorities:
   i. Tobacco Prevention Funding
   ii. Tobacco to 21
   iii. Cessation services coverage

e. Emergency Cardiac and Stroke Systems of Care

**DISCUSSION**

**The WHAT**

- **What are the issues your organization is seeking to address?**
  - **Using policy to create healthier environments, improve access to care, secure funding for programs**
    - **Improve access to care (acute, rehab)**
    - **Continue to reduce tobacco usage**
- **What has been successful (strategies and practices)?**
    - Example: Tobacco tax (could be applied to vapor products too), expand scope of practice for pharmacists to reimburse for services related to CV health, Affordable Care Act
- **What are the key challenges?**
  - **Limited funding available**
  - **Barriers create limited access for some services (cardiac rehab)**

**What do we choose to focus on?**

- Cardiac Rehab
    - Cardiac rehab as prevention → cost avoidance
    - Barriers: co-pays are too high, low-level providers cannot get reimbursed, lack of programs in rural areas
    - What can we do in terms of reimbursement / coverage – must it be done at the federal level? or can we do something in the state?; change rules around hospital incentives to allow to off-set co-pay costs for patients? Allow lower level providers to oversee?
    - ACTIONS:
        - Create a Healthier Washington metric around cardiac rehab participation to put a focus on it and get broader support to improve?
        - Create workgroup to explore policy change?
        - Pursue connection with NWAACVPR and PCNA. Include pharmacists, ECS TAC members, telehealth experts, insurers, OIC.
- Tobacco Control
    - Tobacco – 21
    - Funding for tobacco control program
        - Reframe the problem and how funding is the solution – tobacco use is still a problem, especially for priority populations
        - A fully funded, comprehensive program too hard for legislators to imagine – focus on emergent need?
        - Secure new $ for prevention/cessation (MSA bonus payments, vapor products tax, other) and explore ways to protect the funds
- **What would success look like for this work?**
- **What objectives do we seek to accomplish?**

**The HOW**

- **How do we accomplish this? What specific actions or tasks need to be carried out in order to complete each step?**
- **Who can we increase awareness of existing or new resources?**
- **How do we want to stay accountable to these plans?**

**Overview:**

**Deliverable -**
**Creative solutions for coverage**

| **Action** | **Who** | **By When** |
|---|---|---|
| DOH/AG to continue convening work groups (T21, funding, etc.). Others may join these existing groups. | DOH | Ongoing |
| Explore collaboration with NWAACVPR and PCNA re: cardiac rehab | Susan | September |
| Convene a stakeholder meeting to explore barriers, state-level solutions | Lindsay to contact Susan to jump start | September |
| | | |
| | | |
| | | |

**Meeting Purpose:**
Connecting staff from AHA Affiliates, state health departments and other state and local heart disease and stroke prevention partners to establish and engage in meaningful relationships around Million Hearts® efforts.

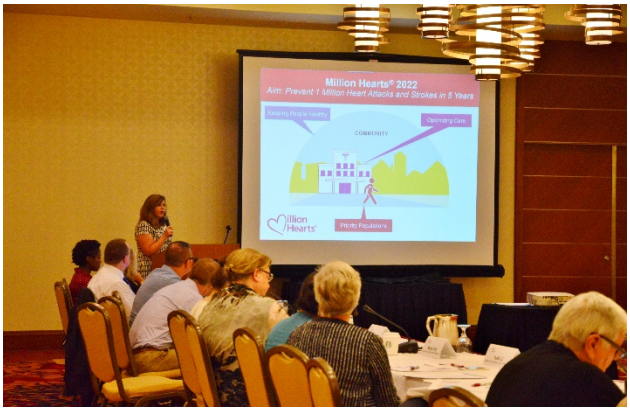
**Meeting Objectives:**
At the end of the meeting, participants will be able to:
1) Identify Million Hearts focused activities for 2017
2) Recognize Million Hearts® evidence-based and practice-based CVD prevention strategies and approaches
3) List partner programs and resources that align with Million Hearts
4) Identify programs efforts that align and ways to work together
5) Create plan for follow-up to increase engagement
6) Recognize key contacts within heart disease and stroke prevention

**Meeting Outcomes:**
Attendees will have expanded their knowledge of evidence based programs, collaboration strategies, tools, resources and connections to align programs and new initiatives that support Million Hearts®.

**Partners:**

American Diabetes Association
American Heart Association
AHA, Puget Sound Division
An Ounce of Prevention
Center for MultiCultural Health
Chelan-Douglas Health District
Franciscan Health Systems
Grant County Health District
Inland Northwest Health Services
National Association of Chronic Disease Directors
National Forum for Heart Disease & Stroke Prevention
People for People
Public Health Seattle & King County
Qualis Health
Quality Food Centers (QFC) Pharmacy
Skagit Regional Health
Swedish Medical Group
Texas A&M University
US Department of Health & Human Services (HHS) Region 10
Washington Center for Nursing
WA State Department of Health
WA State Department of Social and Health Services, Aging and Long-Term Support
The Home and Community Services Division
DSHS/ALTSA/HCS
WA State Health Care Authority
WA State University
YMCA of Pierce and Kitsap Counties

**Million Hearts 2022:**
The goal of Million Hearts is to prevent 1 million heart attacks, strokes, and other cardiovascular events. During the first 5-year phase of Million Hearts®, we made significant progress in many areas. And while final numbers will not be available until 2019, we estimate that up to half a million events may have been prevented from 2012-2016. With new strategies in place, we are hoping to build on our momentum over the next five years.




Million Hearts® 2022 is co-led by the Centers for Disease Control & Prevention and the Centers for Medicare and Medicaid Services. But it is carried out by a variety of partners across federal and state agencies, and private organizations.

Million Hearts® provides a platform to shine light on a selection of evidence-based strategies for cardiovascular disease prevention, and it serves as a learning lab and repository of tools, protocols, and resources for partners to use to implement these strategies.

The important thing to note, however, is that while Million Hearts® provides the platform, the strategies, the tools, protocols and resources, it's the partners who are the ones really driving this initiative.

**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 |

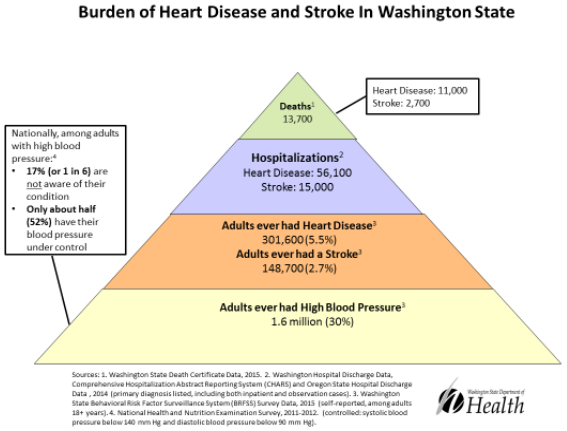
| Improving Outcomes for Priority Populations |
|---|
| Blacks/African Americans |
| 35- to 64-year-olds |
| People who have had a heart attack or stroke |
| People with mental illness or substance use disorders |

*Aspirin when appropriate, Blood pressure control, Cholesterol management, Smoking cessation

Million Hearts®

**Washington State Health Department programs and resources that align with Million Hearts**
Cheryl Farmer, MD
Manager, Heart Disease, Stroke, and Diabetes Prevention Program
Community-Based Prevention Section, Washington State Department of Health

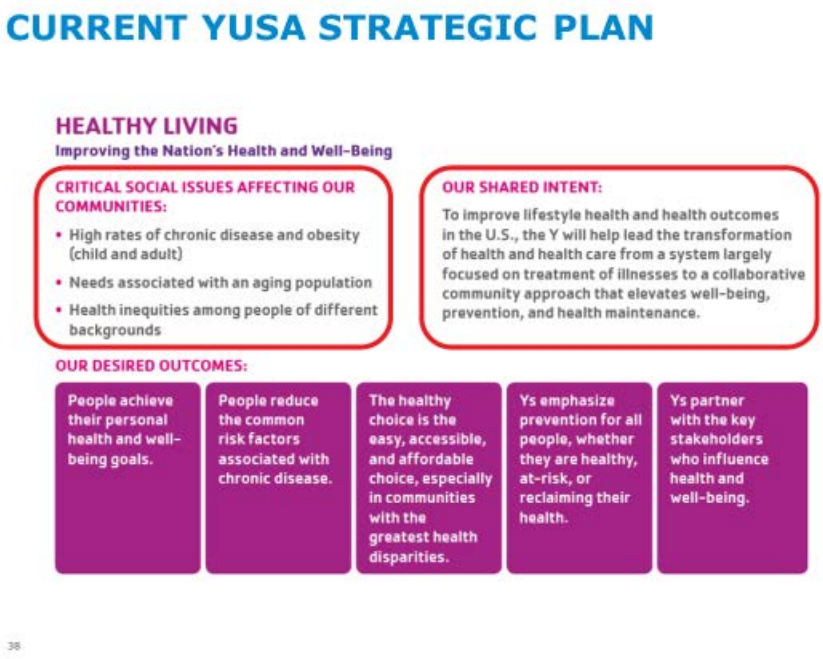
Susan S. Buell
Association Director of Adult Healthy Lifestyles and Chronic Disease
YMCA of Pierce and Kitsap Counties




Through CDC's Division for Heart Disease and Stroke Prevention, DOH has several grants to support their work referred to as 1305 and 1422:

- **Promoting awareness** of the importance of blood pressure control
- **Leverage partnerships** to address the chronic condition of hypertension
- We work with a variety of individuals, organizations, and communities to **offer in-person trainings** on how to accurately measure blood pressure
- **Provide educational materials** in multiple languages to support blood pressure management and control
- **Connect communities to available resources**

**YMCA is a 1422 grantee –** The YMCA's strategic plan aligns with Million Hearts®.




The Blood Pressure Self-Monitoring Program is based on the Check It, Change it Program. They train healthy heart ambassadors to work with high-risk communities. It is a 4-month evidence-based program designed to help persons with high blood pressure better manage their blood pressure by developing the habit of self-monitoring. Through 1422, the YMCA is able to deliver the BPSMP at community sites.

Community partners were pulled together to test the delivery model. They have enrolled over 170 people.

**Qualis Health programs and Resources that Align with Million Hearts**
Jeff Sobotka, PMP, MBA, CPHIMS, CHP and Lisa Packard
Qualis Health, Healthy Hearts Northwest Project

Qualis Health is a leading national population health management organization. The Medicare Quality Innovation Network - Quality Improvement Organization (QIN-QIO) for
Idaho and Washington. This is one of the largest federal programs dedicated to improving health quality at the local level.

Healthy Hearts Northwest has been established to give primary care practices in Idaho, Oregon and Washington the support they need to help patients live healthier and longer. The Agency for Healthcare Research and Quality (AHRQ) has funded the MacColl Center for Health Care Innovation at Group Health Research Institute to conduct a three-year project that helps primary care practices improve their patients' cardiovascular health—while also building capacity for quality improvement. Healthy Hearts Northwest is led by the MacColl Center with its partners, Qualis Health, the Oregon Rural Practice Research Network and the Institute of Translational Health Sciences at the University of Washington. Healthy Hearts Northwest is a cooperative of AHRQ's EvidenceNOW initiative to advance heart health in primary care.

Technical assistance includes:

- Unlimited customized technical assistance including on-site practice visits for 15 months, and monthly phone calls
- Quality Improvement reports for internal use, aligned with PQRS measures
- Optimization of clinical decision support
- Using data to drive improvement through workflow changes
- Clinically focused learning modules for care teams to address common issues in CVD population management
- Data Submission
- PDSA, Webinars, IHI Model for Improvement

Qualis Health's Practice Innovation Network (PIN) - Assists Washington primary care practices to develop quality improvement processes and related reports to help them prepare for value-based reimbursement and improve cardiac care. The goal of the Qualis PIN is to see each participating practice, organization, and the PIN as a whole to improve performance on the selected quality measures.
Technical assistance includes:

- Help all practices improve cardiac care
- Educational webinars
- Share pertinent information from CDC, CMS, etc.
- Focus on ABCS measures
- Higher level of attention
- QI consulting
- CMS evaluation metric based on PIN practices' scores for blood pressure and smoking

**AHA/ASA programs and Resources that Align with Million Hearts**
Western States Affiliate Lindsay Hovind, Senior Director, Government Relations
Elaine Kitamura, Regional Director, Multicultural Initiatives
Kristen VanWart, Sr. Community Health Director, Field Operations/Development
Elizabeth Peterson, Regional Director, Quality & Systems Improvement

Recent Policy successes in WA:

- Emergency Cardiac and Stroke System of Care (2010)
- CPR in Schools (2013)
- Newborn Screening for CCHD (2015)
- Historic investments in Safe Routes to School (2015)
- PE Quality Assessment (2017)
- Seattle Sugary Drink Tax (2017)

Quality and Systems Improvement:

- Improve medical care and education of patients
- Initiation of and adherence to evidence-based, guideline-recommended therapies
- Collection of data to improve quality of care in the hospital and for research
- Celebrate successes

**Resources:**

- Complete Workplace Health Solutions Index http://www.heart.org/HEARTORG/HealthyLiving/WorkplaceHealth/Workplace-Health_UCM_460416_SubHomePage.jsp
- Detailed Playbooks for all 7 best practice categories within Workplace Health Solutions
- My Life Check Health Assessment http://www.heart.org/HEARTORG/Conditions/My-Life-Check---Lifes-Simple-7_UCM_471453_Article.jsp#.WYynd4WcE2w
- Check, Change, Control: Blood Pressure http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/HighBloodPressureToolsResources/Find-a-Check-Change-Control-Program-Near-You_UCM_449325_Article.jsp#.WYynnoWcE2w
- Food and Beverage Tool Kit for a healthy food environment and policies http://www.heart.org/HEARTORG/HealthyLiving/WorkplaceHealth/EmployerResources/Healthy-Workplace-Food-and-Beverage-Toolkit_UCM_465195_Article.jsp#.WYynwIWcE2w

**Target BP:**

http://targetbp.org/

- A call to action motivating medical practices, practitioners and health services organizations to prioritize blood pressure control
- Recognition for healthcare providers who attain high levels of blood pressure control in their patient populations, particularly those who achieve 70, 80 percent or higher control
- A source for tools and assets for healthcare providers to use in practice, including the AHA/ACC/CDC, Hypertension Treatment Algorithm and the AMA's M.A.P. Checklist

**Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in Washington Pre- Survey Results**

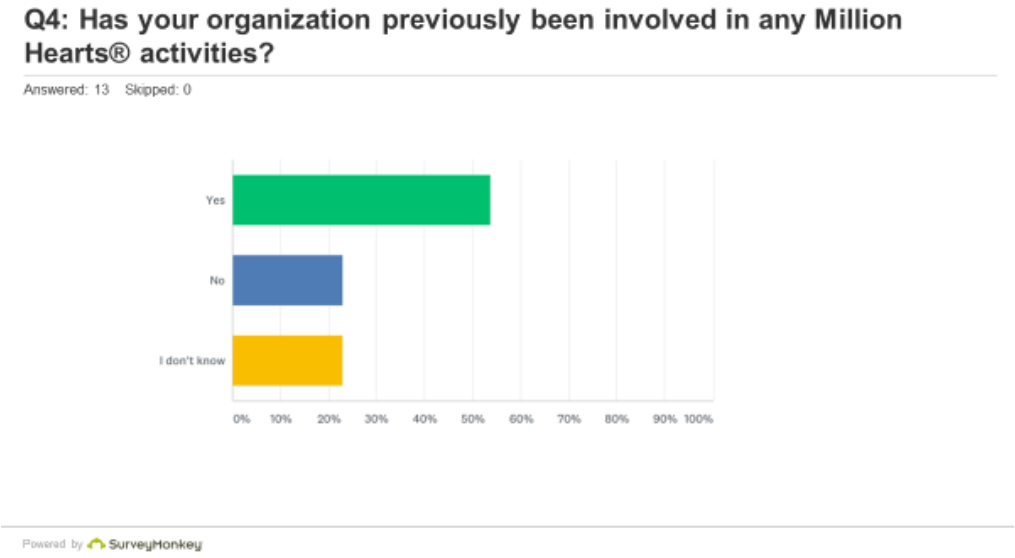
**Respondents:**

- American Heart Association
- Chelan-Douglas Health District
- Grant County Health District
- Inland Northwest Health Services
- Quality Food Centers (QFC) Pharmacy
- Skagit Regional Health
- Swedish Medical Group
- Tacoma Pierce County Health Department
- US Dept. of Health and Human Services-Region 10

- Washington State Department of Health
- Washington State University

**Role in Organization:**

- Manager
  - *Nursing Program*
  - *Community Health*
  - *Stroke Program*
- Coordinator
  - *District Patient Care*
  - *Healthy Communities*
- Health Promotion
- Consultant – Health Services
- Director – Community Wellness
- Government Relations
- Lead - Heart Disease & Stroke Prevention
- Public Health Advisor
- Quality Improvement Specialist
- Research



**Currently work on hypertension control in Washington:**

- Yes-85.7%
  - Information sharing: *Million Hearts hypertension information; Primary care/outreach; Low-literacy level materials*
  - Programs: *Blood pressure management project with Million Hearts "Check It, Change It" curriculum; DPP, Hypertension & Prevention Programs; Coverdell Program*
  - 1422 CDC Grant
  - Research
- No-14.3%

**Currently use community health workers for heart disease/stroke in WA:**

- Yes-78.6%
  - CHW Trainings; Community-based organizations
  - Blood Pressure Projects
    - *"Check It, Change It" Blood Pressure Screening Project*
    - *Blood pressure health kiosks*
  - Collaborate to include CVD in work; Promote physical activity; Nurse Delegations/Private Duty Nursing
- No-21.4%

**Currently work on worksite wellness in WA:**

- Yes-64.3%
  - Wellness coordinator & team; Heart disease prevention team
  - Direct services to employers
  - Organization-sponsored programs
    - *Kroger-sponsored health screening/coaching*
    - *SmartHealth stroke awareness*
- No-35.7%

**Currently work on public policy for heart disease and stroke in WA:**

- Yes-50%
  - Work on policy change directly- *Physical activity, nutrition, tobacco; Emergency response/care for CVD*
  - Coverdell Stroke Community Group
  - Share information with state and local policy makers
- No-50%

**What does success look like at end of the meeting:**

- Learn about Million Hearts program; Learn about projects for local level; How to align national work with existing work; Evidence-based projects that can be replicated locally; Learn about overall plan for Washington State; Engage with state/local partners; Resources for contract nurses; What HCPs/Organizations need from community pharmacists.

**Agenda:**

| Time | Agenda Item/Topic | Speaker/Facilitator |
|---|---|---|
| 9:00 – 9:15 am | **Partner Networking** | |
| 9:15 – 9:30 am | **Welcome and Overview of the Day**<br>**Pama Joyner**<br>Director, Office of Healthy and Safe Communities, Prevention and Community Health, Washington State Department of Health | **Julie Harvill,**<br>**Operations Manager**<br>**Million Hearts®**<br>**Collaboration** |
| | **Introductions**<br>In one sentence, what excites you about your role in heart disease and stroke prevention? | **John Bartkus**<br>**Pensivia** |
| 9:30 – 10:15am | **Million Hearts® 2022**<br>• Million Hearts® Accomplishments<br>• What must happen to prevent?<br>• 2017 Focus<br>**Q and A/Group Interaction** | **Robin Rinker, MPH, CHES**<br>Health Communications Specialist<br>Division for Heart Disease and Stroke Prevention, CDC |
| 10:15 – 10:30am | **Break** | |
| 10:30 – 11:00am | **Washington State Health Department programs and resources that align with Million Hearts**<br>**Q and A**<br>**Group Interaction** | **Cheryl Farmer, MD**<br>Manager<br>Heart Disease, Stroke, and Diabetes Prevention Program<br>Community-Based Prevention Section, Washington State Department of Health |
| 11:00 – 11:15am | **Qualis Health programs and resources that align with Million Hearts**<br>**Q and A**<br>**Group Discussion** | **Jeff Sobotka, PMP, MBA, CPHIMS, CHP**<br>Quality Improvement Consultant, Practice Coach<br>Qualis Health<br>Healthy Hearts Northwest Project |
| 11:15 – 11:30am | **AHA/ASA programs and resources that align with Million Hearts**<br><br>**Q and A** | **Lindsay Hovind**<br>American Heart Association<br>Senior Director<br>Government Relations<br>Western States Affiliate |
| 11:30 am – 12:30pm | **Catered Lunch** | |
| 12:30 – 3:00pm | **Afternoon Breakouts/Facilitated Discussions** | |

| | | |
|---|---|---|
| | Group 1. Hypertension Control<br>Group 2. Role of community health workers and community based organizations in addressing CVD<br>Group 3. Worksite Wellness<br>Group 4. Public Health Policy - Tobacco and Pharmacist | **Session Monitors:**<br>Miriam Patanian<br>Robin Rinker<br>Julia Schneider<br>Julie Harvill<br>April Wallace<br>John Bartkus |
| | **Ways to Work Together and Next Interactions**<br>• Plan for follow-up to increase engagement<br>• Key contacts within heart disease and stroke<br>prevention with state | John Bartkus |
| 2:45 – 3:00p.m | **Evaluation** | Whitney Garney |
| 3:00p.m. | **Wrap Up/Adjourn** | April Wallace |

Thank you!

Public Health Policy Breakout

Hypertension Control Breakout

CHW Breakout

Worksite Wellness Breakout

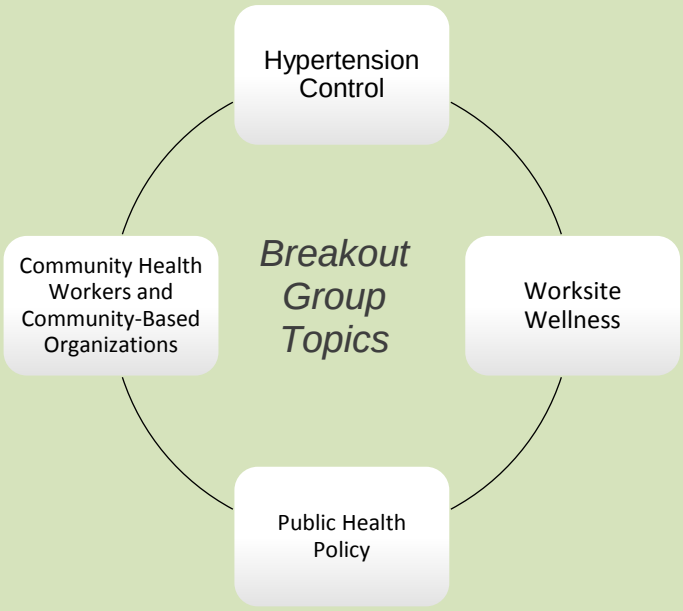
# Advancing Million Hearts ®:
# American Heart Association and Heart Disease and Stroke Prevention Partners Working Together in Washington

*August 10, 2017*

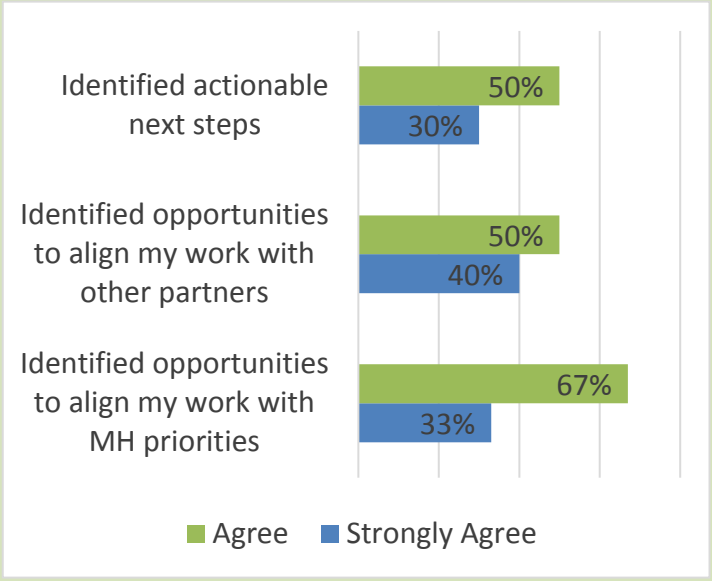
*On August 10, 2017, the American Heart Association (AHA) worked with partners to host the Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in Washington Meeting. The goal of the meeting was for attendees to expand their knowledge of evidence-based programs, collaboration strategies, tools, resources and generate connections to align programs and new initiatives that support Million Hearts® (MH).*

**62 Washington partners attended the meeting representing 37 organizations.**

## Participants attended breakout groups to plan activities and establish action plans.




## Participants felt the meeting allowed them to:




***"This is the first time I received [a] formal overview of the Million Hearts Campaign, so that's very valuable to me…"***

***-Meeting Participant***

***Participants felt the most valuable part of the meeting was…***

Action Networking Meeting Sessions Organizations

# Million Hearts® Resources

Resources for Clinicians:

- **Hypertension Control: Change Package for Clinicians**
  *http://millionhearts.hhs.gov/files/HTN_Change_Package.pdf*
  A quality improvement change package with a listing of process improvements that ambulatory clinical settings can implement as they seek optimal hypertension control.

- **Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians**
  *http://millionhearts.hhs.gov/files/MH_SMBP_Clinicians.pdf*
  A guide to facilitate the implementation of self-measured blood pressure monitoring (SMBP) plus clinical support in preparing care teams to support SMBP, selecting and incorporating clinical support systems, empowering patients, and encouraging health insurance coverage for SMBP plus additional clinical support.

- **Evidence-Based Hypertension Treatment Protocols**
  *http://millionhearts.hhs.gov/tools-protocols/protocols.html*
  A webpage with a hypertension treatment protocol template and featured evidence-based protocols to help clinicians improve blood pressure control by clarifying titration intervals, revealing new treatment options and expanding the types of staff that can assist in a timely follow-up with patients.

- **Tobacco Cessation Protocol**
  A webpage with a tobacco cessation protocol template and featured evidence-based protocols to help clinicians identify patients who use tobacco and systematically deliver appropriate cessation services.
  http://millionhearts.hhs.gov/tools-protocols/protocols.html#TCP

- **Undiagnosed Hypertension**
  *http://millionhearts.hhs.gov/tools-protocols/hiding-plain-sight/index.html*
  A webpage that describes the phenomena of patients with uncontrolled hypertension being seen by clinicians, but remaining undiagnosed; resources, references and case studies are provided to help clinicians find their undiagnosed hypertensive patients.
    - **Hypertension Prevalence Estimator**
      *https://nccd.cdc.gov/MillionHearts/Estimator/*
      An interactive tool health systems and practices can use to start or build on their existing hypertension management quality improvement process by comparing the expected hypertension prevalence generated from the tool with their calculated prevalence.

- **Million Hearts® Clinical Quality Measures (CQM)**
  *http://millionhearts.hhs.gov/data-reports/cqm.html*
  A webpage that displays national clinical quality measures and targets focused on the Million Hearts® ABCS (Aspirin when appropriate, Blood pressure control, Cholesterol management, and Smoking cessation).

- **Medication Adherence Resources**
  https://millionhearts.hhs.gov/tools-protocols/medication-adherence.html
  A webpage with a variety of resources, tools, tip sheets and success stories to help patients take medications correctly and consistently.

- **Health IT Resources:**
  https://millionhearts.hhs.gov/tools-protocols/tools/health-IT.html
  A webpage with health IT resources and tools that enable easier clinical quality reporting and improvement.

Clinically-focused Programs:

- **Million Hearts® Hypertension Control Challenge**
  *http://millionhearts.hhs.gov/partners-progress/champions/index.html*

- **Million Hearts® Cardiovascular Disease Risk Reduction Model**
  *https://innovation.cms.gov/initiatives/Million-Hearts-CVDRRM/*

- **EvidenceNOW: Advancing Heart Health in Primary Care**
  *http://www.ahrq.gov/professionals/systems/primary-care/evidencenow.html*

Public Health Resources and Programs:

- **Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners**
  *http://millionhearts.hhs.gov/files/MH_SMBP.pdf*

- **CDC State Heart Disease and Stroke Prevention Programs**
  *http://www.cdc.gov/dhdsp/programs/index.htm*

Tools for Patients:

- **Heart Age Predictor**
  *http://www.cdc.gov/vitalsigns/cardiovasculardisease/heartage.html*

- **Blood Pressure Wallet Card**
  *http://millionhearts.hhs.gov/files/BP_Wallet_Card.pdf*

- **Smoke Free (SF)**
  *http://smokefree.gov/*

- **Million Hearts® Videos: Personal Stories**
  *http://millionhearts.hhs.gov/news-media/media/videos.html#ps*

Community Engagement:

- **Million Hearts® 2022 Partner Materials**
  https://millionhearts.hhs.gov/about-million-hearts/partner-materials.html

- **Cardiovascular Health: Action Steps for Employers**
  *http://millionhearts.hhs.gov/files/MH_Employer_Action_Guide.pdf*

Supportive Campaigns:

- **Mind Your Risks**
  *https://mindyourrisks.nih.gov/index.html*

- **Tips from Former Smokers**
  *http://www.cdc.gov/tobacco/campaign/tips/index.html*

# Preventing 1 million heart attacks and strokes by 2022

Organization name

Presenter's name

Credentials

# Million Hearts® 2022

- **Aim:** Prevent 1 million—or more—heart attacks and strokes in the next 5 years
- National initiative co-led by:
  - Centers for Disease Control and Prevention (CDC)
  - Centers for Medicare & Medicaid Services (CMS)
- Partners across federal and state agencies and private organizations

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# Heart Disease and Stroke in the U.S.

- More than **1.5 million** people in the U.S. suffer from heart attacks and strokes per year[1]
- More than **800,000** deaths per year from cardiovascular disease (CVD)[1]
- CVD costs the U.S. **hundreds of billions** of dollars per year[1]
- CVD is the greatest contributor to racial disparities in life expectancy[2]

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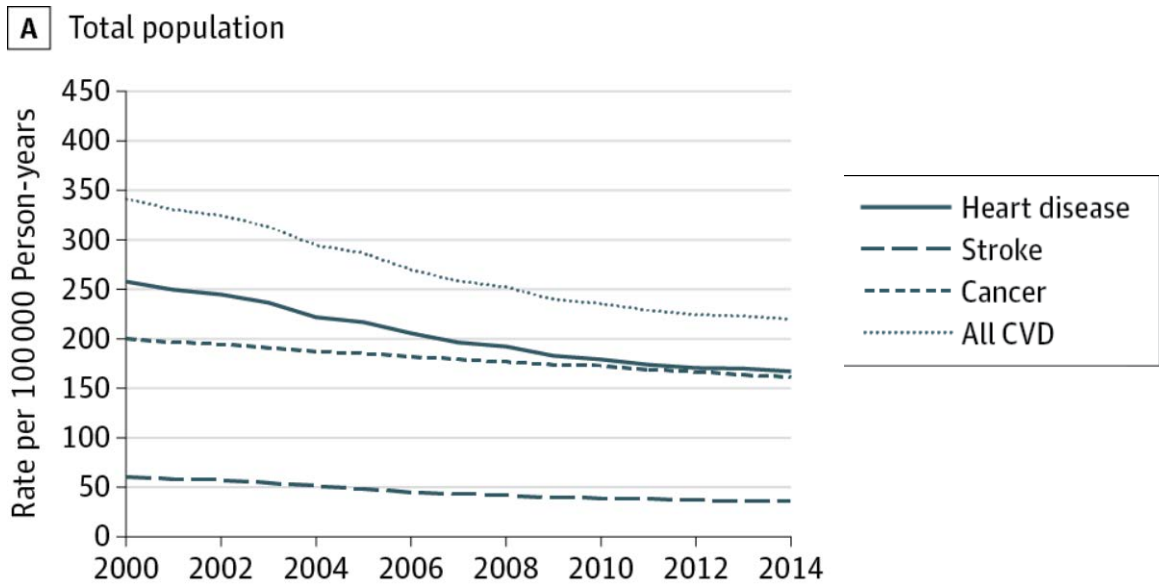
References
1. Benjamin EJ, Blaha MJ, Chiuve SE, Cushman M, Das SR, Deo R, et al. Heart Disease and Stroke Statistics-2017 Update: A Report From the American Heart Association. Circulation 2017;135(10):e146–603.
2. Kochanek KD, Arias E, Anderson RN. How did cause of death contribute to racial differences in life expectancy in the United States in 2010? NCHS data brief, no 125. Hyattsville, MD: National Center for Health Statistics. 2013

# Heart Disease and Stroke Trend

While CV deaths have been declining for the past 40 years, the **reduction in these deaths has slowed**.

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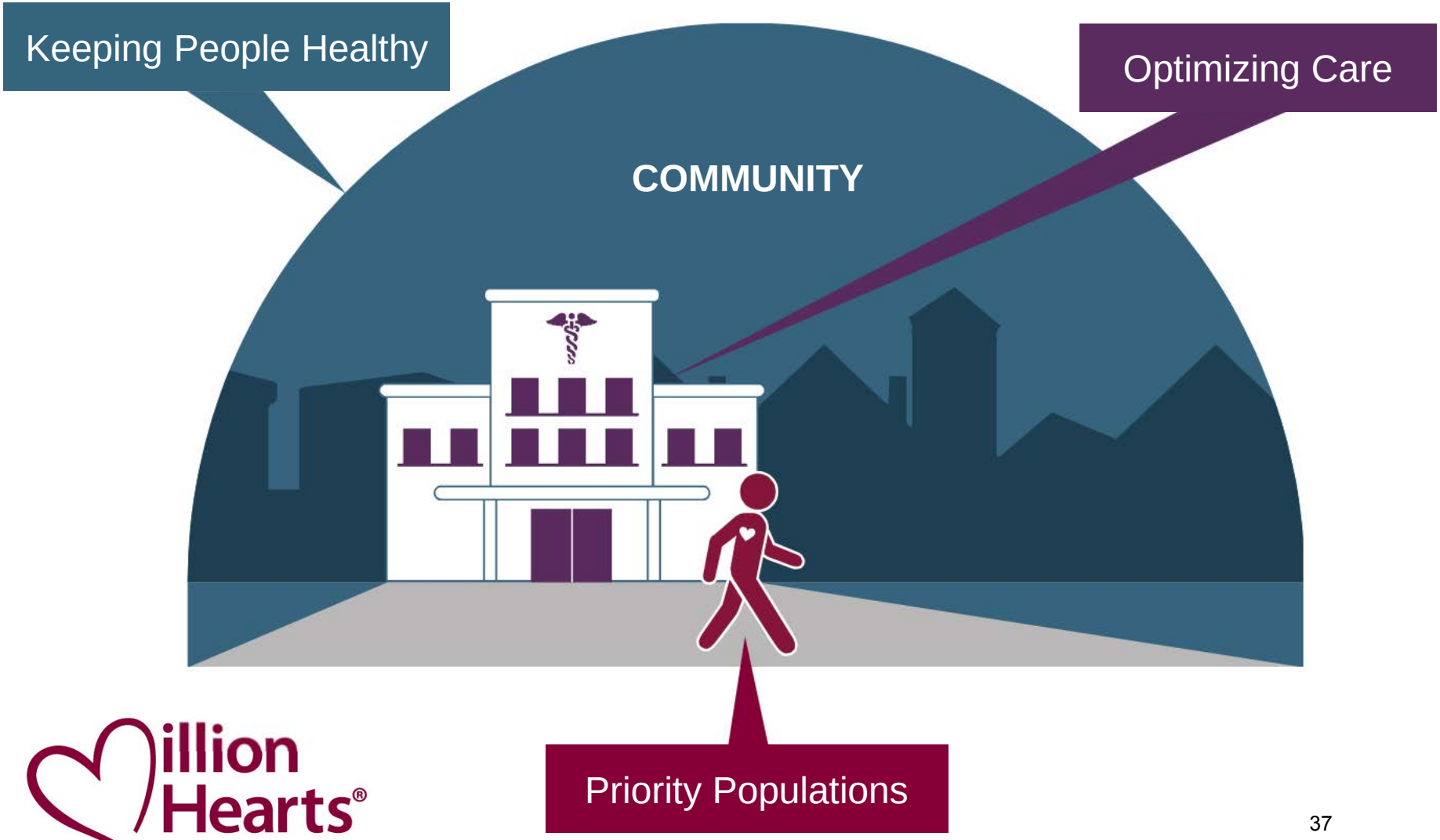
Sidney S, Quesenberry CP, Jaffe MG, Sorel M, Nguyen-Huynh MN, Kushi LH, et al. Recent trends in cardiovascular mortality in the United States and public health goals. *JAMA Cardiol* 2016;1(5):594–9

# Million Hearts® 2022
## *Design*



# Million Hearts® 2022
## *Priorities*

| Keeping People Healthy |
| --- |
| Reduce Sodium Intake |
| Decrease Tobacco Use |
| Increase Physical Activity |

| Optimizing Care |
| --- |
| Improve ABCS* |
| Increase Use of Cardiac Rehab |
| Engage Patients in Heart-healthy Behaviors |

| Improving Outcomes for Priority Populations |
| --- |
| Blacks/African Americans |
| 35- to 64-year-olds |
| People who have had a heart attack or stroke |
| People with mental illness or substance use disorders |

*Aspirin when appropriate, Blood pressure control, Cholesterol management, Smoking cessation

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# Keeping People Healthy

| Goals | Effective Public Health Strategies |
|---|---|
| **Reduce Sodium Intake**<br>Target: 20% | • Enhance consumers' options for lower sodium foods<br>• Institute healthy food procurement and nutrition policies |
| **Decrease Tobacco Use**<br>Target: 20% | • Enact smoke-free space policies that include e-cigarettes<br>• Use pricing approaches<br>• Conduct mass media campaigns |
| **Increase Physical Activity**<br>Target: 20%<br>(Reduction of inactivity) | • Create or enhance access to places for physical activity<br>• Design communities and streets that support physical activity<br>• Develop and promote peer support programs |

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# Optimizing Care

| Goals | Effective Health Care Strategies |
|---|---|
| **Improve ABCS*** Targets: 80% | ***High Performers Excel in the Use of…***<br>• **Technology**—decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care<br>• **Teams**—including pharmacists, nurses, community health workers, and cardiac rehab professionals<br>• **Processes**—treatment protocols; daily huddles; ABCS scorecards; proactive outreach; finding patients with undiagnosed high BP, high cholesterol, or tobacco use<br>• **Patient and Family Supports**—training in home blood pressure monitoring; problem-solving in medication adherence; counseling on nutrition, physical activity, tobacco use, risks of particulate matter; referral to community-based physical activity programs and cardiac rehab |
| **Increase Use of Cardiac Rehab** Target: 70% | |
| **Engage Patients in Heart-healthy Behaviors** Targets: TBD | |

*Aspirin when appropriate, Blood pressure control, Cholesterol management, Smoking cessation

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# Improving Outcomes for Priority Populations

| Priority Populations | Major Strategies |
|---|---|
| **Blacks/African Americans** | Improving hypertension control |
| **35- to 64-year-olds, because event rates are rising** | • Improving hypertension control and statin use<br>• Increasing physical activity |
| **People who have had a heart attack or stroke** | • Increasing cardiac rehab referral and participation<br>• Avoiding exposure to particulate matter |
| **People with mental illness or substance use disorders** | Reducing tobacco use |

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# Million Hearts®
## Resources and Tools

- **Action Guides**—Hypertension control; Self-measured blood pressure monitoring (SMBP); Tobacco cessation; Medication adherence
- **Protocols**—Hypertension treatment; Tobacco cessation; Cholesterol management
- **Tools**—Hypertension prevalence estimator; ASCVD risk estimator
- **Health IT**
- **Clinical Quality Measures**
- **Consumer Resources and Tools**

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# Our Commitment

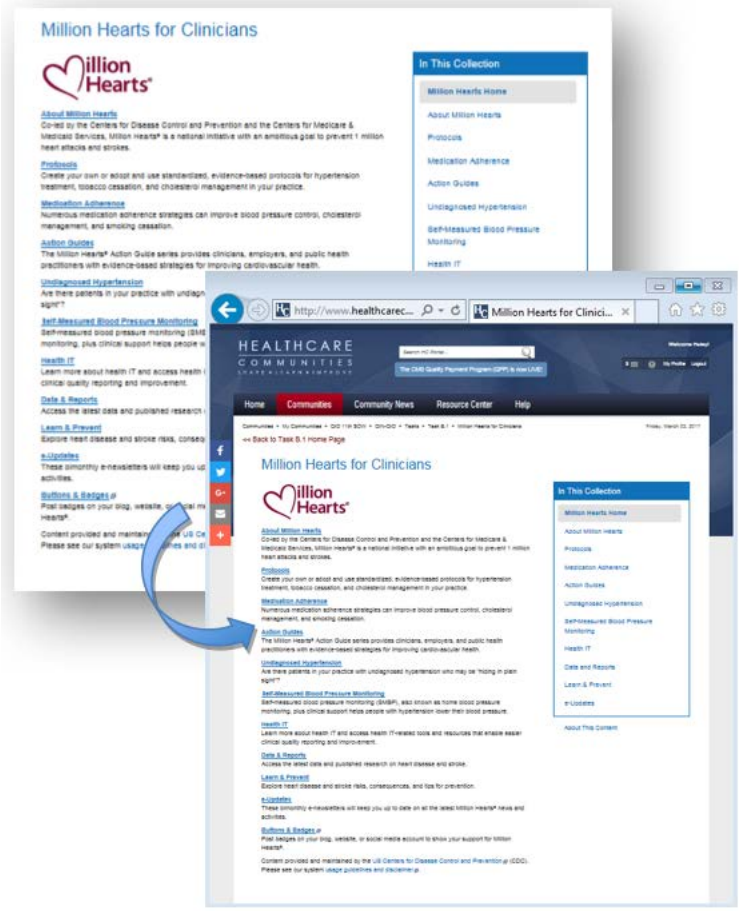
- Partner statement of commitment
- Description of intended actions

# Stay Connected

- Million Hearts® eUpdate Newsletter
- Million Hearts® on Facebook and Twitter
- Million Hearts® Website
- Million Hearts® for Clinicians Microsite

# Million Hearts® for Clinicians Microsite

- Features Million Hearts® protocols, action guides, and other QI tools
- Syndicates **LIVE** Million Hearts® on your website for your clinical audience
- Requires a small amount of HTML code—customizable by color and responsive to layouts and screen sizes
- Content is free, cleared, and continuously maintained by CDC




Available at https://tools.cdc.gov/medialibrary/index.aspx#/microsite/id/279017

# Million Hearts® 2022

## Preventing 1 Million Heart Attacks and Strokes by 2022

**Every 40 seconds, an adult dies from a heart attack, stroke, or other adverse outcomes of cardiovascular disease (CVD)**. These deaths account for about one third (30.9%) of all deaths in the United States, or more than 800,000 deaths each year. About 1 in 5 of these deaths is a person younger than 65. Heart disease and stroke can also lead to other serious illnesses, disabilities, and lower quality of life.

The economic toll of CVD is high—more than $316 billion each year in the United States—with CVD treatment accounting for about $1 of every $7 spent on health care in this country.

While cardiovascular deaths have been declining for the past 40 years, the reduction in these deaths has slowed since 2011, indicating the need for focused, sustained action by public and private partners to improve our nation's cardiovascular health.

## Million Hearts® 2022

Million Hearts® 2022 is a national initiative co-led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services to prevent 1 million heart attacks and strokes in 5 years. The initiative focuses partner actions on a small set of priorities selected for their impact on heart disease, stroke, and related conditions.

## Million Hearts® 2022 Goals

Reaching these goals will result in 1 million fewer heart attacks and strokes in the next 5 years:

- 20% reduction in sodium intake
- 20% reduction in tobacco use
- 20% reduction in physical inactivity
- 80% performance on the ABCS Clinical Quality Measures
- 70% participation in cardiac rehab among eligible patients

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millionhearts.hhs.gov

## Stay Connected

Learn more about Million Hearts® and how you can join this national effort and take action to prevent 1 million heart attacks and strokes by 2022.

- Visit **millionhearts.hhs.gov**.
- Connect with **Million Hearts®** on Facebook.
- Follow **@MillionHeartsUS** on Twitter.
- Sign up for the Million Hearts® e-Update at **millionhearts.hhs.gov/news-media**.

## What You Can Do

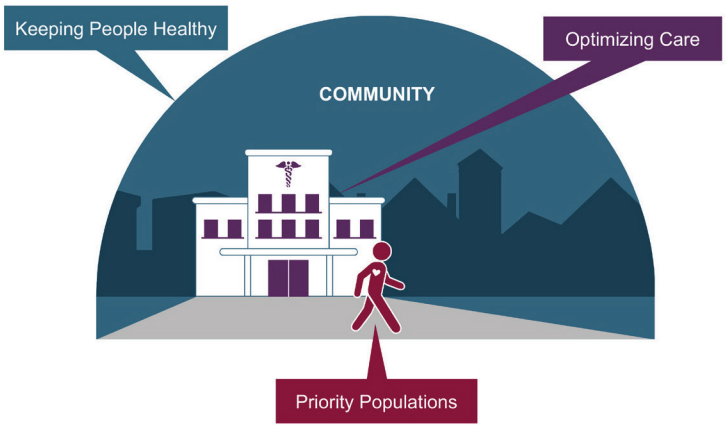
The only way we—as a nation—will meet the Million Hearts® goals is through the collective and focused action of a diverse range of partners.

As a Million Hearts® partner, determine where your individual or organizational mission aligns with the Million Hearts® priorities and explore the evidence-based strategies most suited to your talents, interests, and resources. Check out the **Million Hearts® 2022 framework** and commit with us to carry out the priority actions needed to prevent 1 million heart attacks and strokes.

## Million Hearts® 2022 Priorities

Million Hearts® has set the following priorities to meet the aim of preventing 1 million heart attacks and strokes by 2022:

- ***Keeping people healthy*** with public health efforts that promote healthier levels of sodium consumption, increased physical activity, and decreased tobacco use.
- ***Optimizing care*** by using teams, health information technology, and evidence-based processes to improve the ABCS (Aspirin when appropriate, Blood pressure control, Cholesterol management, and Smoking cessation), increase use of cardiac rehab, and enhance heart-healthy behaviors.
- ***Improving outcomes for priority populations*** selected based on data showing a significant cardiovascular health disparity, evidence of effective interventions, and partners ready to act. Populations include Blacks/African Americans, 35- to 64-year-olds, people who have had a heart attack or stroke, and people with mental illness or substance use disorders.

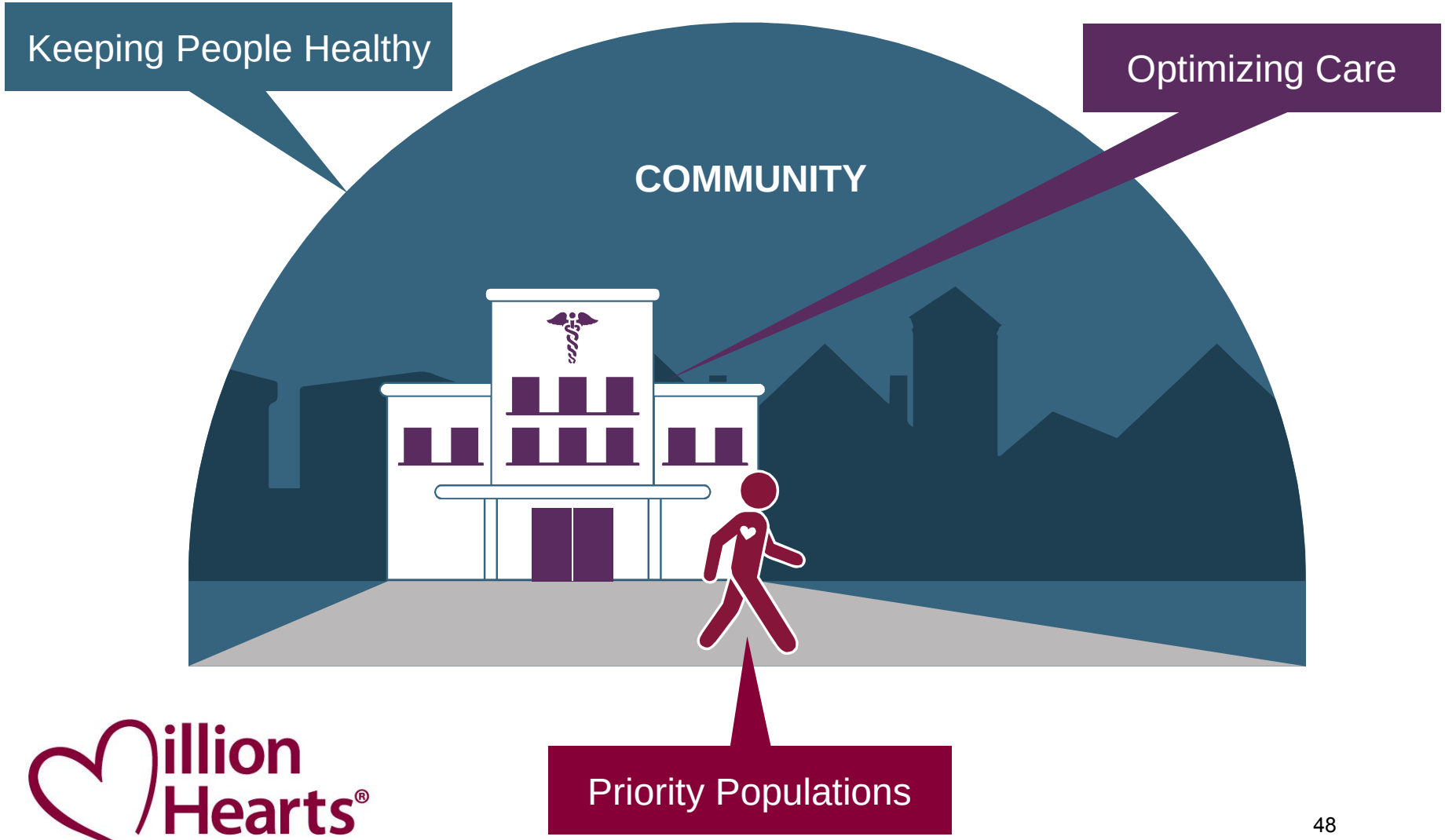





**Learn more by visiting millionhearts.hhs.gov**

April 2017

# Million Hearts® 2022
## *Design*



# Million Hearts® 2022
## *Priorities*

| Keeping People Healthy |
| --- |
| Reduce Sodium Intake |
| Decrease Tobacco Use |
| Increase Physical Activity |

| Optimizing Care |
| --- |
| Improve ABCS* |
| Increase Use of Cardiac Rehab |
| Engage Patients in Heart-healthy Behaviors |

| Improving Outcomes for Priority Populations |
| --- |
| Blacks/African-Americans |
| 35-64 year olds |
| People who have had a heart attack or stroke |
| People with mental illness or substance use disorders |

*Aspirin, Blood pressure control, Cholesterol management, Smoking cessation

Million Hearts®

# Keeping People Healthy

| Goals | Effective Public Health Strategies |
|---|---|
| **Reduce Sodium Intake**<br>20% Target | • Enhance consumers' options for lower sodium foods<br>• Institute healthy food procurement and nutrition policies |
| **Decrease Tobacco Use**<br>20% Target | • Enact smoke-free space policies that include e-cigarettes<br>• Use pricing approaches<br>• Conduct mass media campaigns |
| **Increase Physical Activity**<br>20% Target<br>(Reduction of inactivity) | • Create or enhance access to places for physical activity<br>• Design communities and streets that support physical activity<br>• Develop and promote peer support programs |

Million Hearts®

# Optimizing Care

| Goals | Effective Healthcare Strategies |
|---|---|
| **Improve ABCS*** 80% Targets | ***High Performers Excel in the Use of…….*** • **Technology** – decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care • **Teams** – including pharmacists, nurses, community health workers, cardiac rehab professionals • **Processes** – treatment protocols; daily huddles; ABCS scorecards; proactive outreach; finding patients with undiagnosed high BP, high cholesterol, or tobacco use • **Patient and Family Supports** – training in home blood pressure monitoring; problem-solving in medication adherence; counseling on nutrition, physical activity, tobacco use, risks of particulate matter; referral to community-based physical activity programs and cardiac rehab |
| **Increase Use of Cardiac Rehab** 70% Target | |
| **Engage Patients in Heart-healthy Behaviors** Targets TBD | |

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*Aspirin, Blood pressure control, Cholesterol management, Smoking cessation

# Improving Outcomes for Priority Populations

| Priority Populations | Major Strategies |
|---|---|
| **Blacks/African-Americans** | Improving hypertension control |
| **35-64 year olds—because event rates are rising** | • Improving hypertension control and statin use<br>• Increasing physical activity |
| **People who have had a heart attack or stroke** | • Increasing cardiac rehab referral & participation<br>• Avoiding exposure to particulate matter |
| **People with mental illness or substance use disorders** | Reducing tobacco use |

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# Tools and Resources

**http://www.heart.org**

## Online Tools

- **Check. Change. Control. Tracker** (https://www.ccctracker.com)
  A new online tool to help you track your blood pressure readings and connect with a volunteer health mentor to share your results and progress. Signing up is easy, you just need a campaign code which you can receive by contacting your local AHA affiliate who can also provide more information on the program. If there isn't an AHA office near you, go to www.ccctracker.com/aha and find the campaign code on the map for your state and sign up.

- **My Life Check** (http://tools.bigbeelabs.com/aha/tools/mlc/)
  Get a full heart health assessment with this tool based on many years of research.

- **Heart Attack Risk Calculator** (http://www.cvriskcalculator.com/)
  Calculate your 10-year risk of heart disease or stroke using the ASCVD algorithm published in 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk

- **High Blood Pressure Health Risk Calculator** (http://tools.bigbeelabs.com/aha/tools/hbp/)
  Enter your latest blood pressure reading to learn your risk of having a heart attack, a stroke, and developing heart failure and kidney disease. You'll also learn how a few lifestyle changes can lower your blood pressure and your health risks. You can print your risk report to review and discuss with your healthcare professional.

## Resources

- **Target: BP** (http://targetbp.org)
  Target: BP is a nationwide initiative aimed at controlling high blood pressure and reducing the growing number of Americans who have heart attacks and stroke. The initiative is co-led by the American Heart Association (AHA) and the American Medical Association (AMA) to help physicians, care teams and patients achieve better blood pressure control in accordance with current AHA guidelines.

- **EmPowered to Serve**
  (http://www.empoweredtoserve.org)
  A multicultural initiative that works to influence faith-based as well as urban housing channels to build strategic alliances that support a "culture of health" through healthy living, enhancing the chain of survival, and improving the environment.

- **Get With The Guidelines**
  (http://www.heart.org/HEARTORG/Professional/GetWithTheGuidelinesHFStroke/Get-With-The-Guidelines---HFStroke_UCM_001099_SubHomePage.jsp
  Get With The Guidelines programs are in-hospital programs for improving stroke, heart failure, resuscitation, and AFib care by promoting consistent adherence to
  the latest evidence-based practices. The program provides hospitals with access to: web-based Patient Management Tool™ (powered by Quintiles Real World and Late Phase Research), clinical decision support, robust registry, real-time benchmarking capabilities and other performance improvement methodologies toward the goal of enhancing patient outcomes and saving lives.

- **Check. Change. Control. (CCC)**
  (http://www.heart.org/HEARTORG/Conditions/More/ToolsForYourHeartHealth/Check-Change-iControli-Community-Partner-Resources_UCM_445512_Article.jsp#.WVQTmU0kvIU)
  Check. Change. *Control*. is an evidence-based hypertension management program that utilizes blood pressure self-monitoring to empower patients/participants to take ownership of their cardiovascular health. The program incorporates the concepts of remote monitoring and online tracking as key features to improve outcomes in hypertension management, physical activity, and weight reduction.
  - **Check. Change. Control. Cholesterol Patient Guide**
    (http://www.heart.org/mycholesterolguide)

- **AHA's Smoking Cessation Tools and Resources**
  http://www.heart.org/HEARTORG/GettingHealthy/QuitSmoking/Quit-Smoking_UCM_001085_SubHomePage.jsp

- **AHA Healthy Workplace Food and Beverage Toolkit July 2016**
  http://www.heart.org/HEARTORG/GettingHealthy/WorkplaceWellness/WorkplaceWellnessResources/Healthy-Workplace-Food-and-Beverage-Toolkit-Resources_UCM_465206_Article.jsp

# Washington
# 2018 Draft Public Policy Agenda

***Building healthier lives, free of cardiovascular diseases and stroke.***

**The American Heart Association / American Stroke Association supports and advocates for public policies that will help improve the cardiovascular health of all Americans by 20 percent while reducing deaths by coronary heart disease and stroke by 20 percent by 2020.**

**Healthy Living: Tobacco Free**

- Raise the minimum legal sale age for all tobacco products, including e-cigarettes, to 21 years.

**Quality Systems of Care**

- Enhance Washington's statewide Emergency Cardiac and Stroke System of Care to improve patient outcomes for those suffering a stroke or ST-segment elevation myocardial infarction (STEMI).

**Healthy Eating & Active Living**

- Pursue regulations to establish stronger standards for nutrition, physical activity and screen time in early child care settings.
- Expand incentives offered to Supplemental Nutrition Assistance Program (SNAP) recipients to increase SNAP benefits when used to purchase fruits and vegetables.
- Monitor and support implementation of Seattle's sugary drink tax.

## Advancing Million Hearts®: AHA and State Heart Disease and Stroke Partners Working Together in Washington

August 10, 2017
9:00 AM to 3:00 PM PT

*Seattle Airport Marriott Hotel*
*3201 South 176th Street*
*Seattle, WA 98188*

## Welcome & Overview of the Day

**Julie Harvill, Operations Manager**
*Million Hearts® Collaboration*

**Pama Joyner, Director**
*Office of Healthy and Safe Communities, Prevention and Community Health, Washington State Department of Health*

## Agenda

9:00 AM * WELCOME AND OVERVIEW OF THE DAY
* INTRODUCTIONS
* MILLION HEARTS® 2022
* PROGRAMS AND RESOURCES THAT ALIGN WITH MILLION HEARTS®
  - WASHINGTON STATE HEALTH DEPARTMENT
  - QUALIS
  - AHA/ASA
11:30 AM * CATERED LUNCH
12:20 PM * AFTERNOON BREAKOUTS - WORKGROUPS
3:00 PM * WRAP UP / ADJOURN

## Expectations - Approach for the Day

**John Bartkus, PMP, CPF**
*Principal Program Manager, Pensivia*

## Introductions:

1. Name
2. Organization
3. What excites you about your role in heart disease and stroke prevention? *(one sentence)*

## Logistics – Preparing for Afternoon Workgroups

| 1 Hypertension Control | 2 Role of community health workers and community based organizations | 3 Worksite Wellness | 4 Public Health Policy - Advancing the ABCS |
|---|---|---|---|
| **Cheryl Farmer, Elaine Kitamura, Jeff Sobotka** Miriam Patanian | **Marissa Floyd, Alexandro Pow Sang, Debbie Spink** Julia Schneider April Wallace | **Sara Eve Sarliker, Kristen VanWart** Julie Harvill Mary Jo Garofoli | **Lindsey Hovind** Robin Rinker Whitney Garney |

**ACTION**: Before lunch is over, please add your name to the Flip-chart for the Workgroup you plan to attend/engage.

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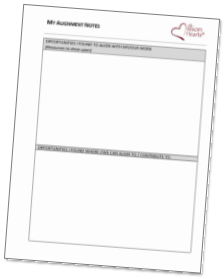
**A key focus for the day…**

**ALIGNMENT**

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



Opportunities I found to:
* Align with My work
* Align with Others work

If "Alignment" is a key goal of this meeting, then what would evidence of cultivating alignment be?

# Preventing 1 Million Heart Attacks and Strokes by 2022

**Robin Rinker, MPH**
*Health Communications Specialist*
*Division for Heart Disease and Stroke Prevention*
*Centers for Disease Control and Prevention*

Million Hearts®

## Million Hearts® 2022

- **Aim:** Prevent 1 million—or more—heart attacks and strokes in the next 5 years
- National initiative co-led by:
  - Centers for Disease Control and Prevention (CDC)
  - Centers for Medicare & Medicaid Services (CMS)
- Partners across federal and state agencies and private organizations

Million Hearts®

## Heart Disease and Stroke in the U.S.

- More than **1.5 million** people in the U.S. suffer from heart attacks and strokes per year[1]
- More than **800,000** deaths per year from cardiovascular disease (CVD)[1]
- CVD costs the U.S. **hundreds of billions** of dollars per year[1]
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Million Hearts®

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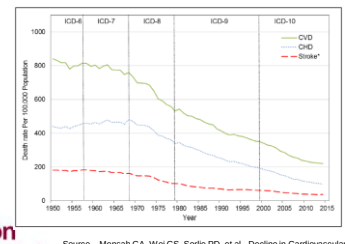
2. Kochanek KD, Arias E, Anderson RN. How did cause of death contribute to racial differences in life expectancy in the United States in 2010? NCHS data brief, no 125. Hyattsville, MD: National Center for Health Statistics. 2013

## Heart Disease and Stroke Trends 1950-2015

While CV deaths have been declining for the past 40 years, the **reduction in these deaths has slowed**.

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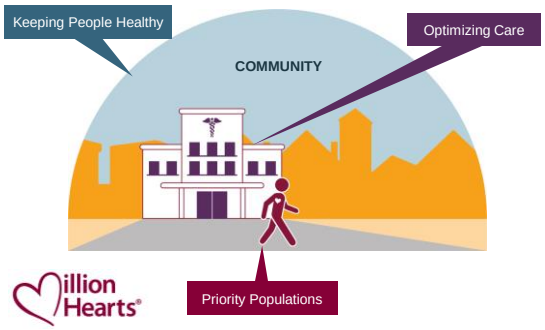
Source – Mensah GA, Wei GS, Sorlie PD, et al. Decline in Cardiovascular Mortality – Possible Causes and Implications. Circulation Research. 2017;120:366-380.

## Million Hearts® 2022
*Aim: Prevent 1 Million Heart Attacks and Strokes in 5 Years*




## 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 |
| 35- to 64-year-olds |
| People who have had a heart attack or stroke |
| People with mental illness or substance use disorders |

*Aspirin use when appropriate, Blood pressure control, Cholesterol management, Smoking cessation

## Keeping People Healthy

| Goals | Effective Public Health Strategies |
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| **Reduce Sodium Intake**<br>Target: 20% | • Enhance consumers' options for lower sodium foods<br>• Institute healthy food procurement and nutrition policies |
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| **Increase Physical Activity**<br>Target: 20%<br>(Reduction of inactivity) | • Create or enhance access to places for physical activity<br>• Design communities and streets that support physical activity<br>• Develop and promote peer support programs |

## Optimizing Care

| Goals | Effective Health Care Strategies |
|---|---|
| **Improve ABCS***<br>Targets: 80% | ***High Performers Excel in the Use of…***<br>• **Teams**—including pharmacists, nurses, community health workers, and cardiac rehab professionals<br>• **Technology**—decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care<br>• **Processes**—treatment protocols; daily huddles; ABCS scorecards; proactive outreach; finding patients with undiagnosed high BP, high cholesterol, or tobacco use<br>• **Patient and Family Supports**—training in home blood pressure monitoring; problem-solving in medication adherence; counseling on nutrition, physical activity, tobacco use, risks of particulate matter; referral to community-based physical activity programs and cardiac rehab |
| **Increase Use of Cardiac Rehab**<br>Target: 70% | |
| **Engage Patients in Heart-healthy Behaviors**<br>Targets: TBD | |

*Aspirin use when appropriate, Blood pressure control, Cholesterol management, Smoking cessation

## Improving Outcomes for Priority Populations

| Priority Population | Intervention Needs | Strategies |
|---|---|---|
| **Blacks/African Americans** | • Improving hypertension control | • Targeted protocols<br>• Medication adherence strategies |
| **35-64 year olds** | • Improving HTN control and statin use<br>• Decreasing physical inactivity | • Targeted protocols<br>• Community-based program enrollment |
| **People who have had a heart attack or stroke** | • Increasing cardiac rehab referral and participation<br>• Avoiding exposure to particulate matter | • Automated referrals, hospital CR liaisons, referrals to convenient locations<br>• Air Quality Index tools |
| **People with mental illness or substance abuse disorders** | • Reducing tobacco use | • Integrating tobacco cessation into behavioral health treatment<br>• Tobacco-free mental health and substance use treatment campuses<br>• Tailored quitline protocols |

## Million Hearts®
Resources and Tools

- **Action Guides**—Hypertension control; Self-measured blood pressure monitoring (SMBP); Tobacco cessation; Medication adherence
- **Protocols**—Hypertension treatment; Tobacco cessation; Cholesterol management
- **Tools**—Hypertension prevalence estimator; ASCVD risk estimator
- **Health IT**
- **Clinical Quality Measures**
- **Consumer Resources and Tools**

## Million Hearts® Hypertension Champion in Washington State

**2014**: Peninsula Community Health Services, Bremerton, Washington

**2015**: International Community Health Services, Seattle, Washington

## Partner Opportunities: Hospitals
*Sample Actions to Consider*

- **Action:** Make healthy food and beverage choices available to patients, visitors, and staff
  - **Resource:** HHS/GSA Health and Sustainability Guidelines for Federal Concessions and Vending Operations
  - **Success Story:** Sodium Reduction Community Program Los Angeles County Department of Public Health
- **Action:** Implement comprehensive smoke-free policies
  - **Resource:** The Community Guide: Tobacco Use and Secondhand Smoke Exposure: Smoke-Free Policies
  - **Success Story:** Communities Putting Prevention to Work: Tobacco Use Prevention and Control
- **Action:** Institute automatic referral of eligible patients to cardiac rehab
  - **Resource:** Increasing Cardiac Rehabilitation Participation From 20% to 70%: A Road Map From the Million Hearts Cardiac Rehabilitation Collaborative

## Partner Opportunities: Employers
*Sample Actions to Consider*

- **Action:** Make healthy food and beverage choices available to all employees
  - **Resource:** HHS/GSA Health and Sustainability Guidelines for Federal Concessions and Vending Operations
  - **Success Story:** Sodium Reduction Community Program Los Angeles County Department of Public Health
- **Action:** Develop and support policies at worksites to encourage use of tobacco cessation services.
  - **Resource:** The Community Guide: Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions
  - **Success Story:** North Carolina Division of Public Health, Tobacco Prevention and Control Branch: Expanding Comprehensive Coverage for Tobacco Cessation
- **Action:** Provide environmental supports for recreation or physical activity (e.g., onsite exercise facility, walking trails, bicycle racks).
  - **Resource:** CDC Worksite Health ScoreCard
  - **Success Story:** Bike Share Program Offers California State Employees Another Way to Be Active

## Partner Opportunities: Clinical Care Teams
*Sample Actions to Consider*

- **Action:** Use standardized treatment protocols for hypertension treatment, tobacco cessation, and cholesterol management
  - **Resource:** CDC: Million Hearts® Protocols
  - **Success Story:** 2014 Hypertension Control Champions: Large Health Systems
- **Action:** Implement self-measured blood pressure monitoring (SMBP) interventions with clinical support
  - **Resource:** Million Hearts® Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians
  - **Success Stories:** 2013 Hypertension Control Champion: Nilesh V. Patel, MD; 2015 Hypertension Control Champion: Reliant Medical Group
- **Action:** Improve performance on Million Hearts® clinical quality measures on aspirin, BP control, cholesterol, smoking cessation, and cardiac rehab
  - **Resource:** Million Hearts® ABCS measures
  - **Success Story:** Association of State and Territorial Health Officials (ASTHO) Million Hearts Minnesota
- **Action:** Leverage electronic health record (EHR) systems to excel in the ABCS
  - **Resource:** Million Hearts® EHR Optimization Guides
  - **Success Story:** Michigan Center for Effective IT Adoption

## Stay Connected

- Million Hearts® eUpdate Newsletter
- Million Hearts® on Facebook and Twitter
- Million Hearts® Website
- Million Hearts® for Clinicians Microsite


## Million Hearts® for Clinicians Microsite

- Features Million Hearts® protocols, action guides, and other QI tools
- Syndicates **LIVE** Million Hearts® on your website for your clinical audience
- Requires a small amount of HTML code—customizable by color and responsive to layouts and screen sizes
- Content is free, cleared, and continuously maintained by CDC

Available at https://tools.cdc.gov/medialibrary/index.aspx#/microsite/id/279017

Million Hearts®

## Q & A

## Group Interaction

Million Hearts®

## Break

Resume at …

## WASHINGTON STATE HEALTH DEPARTMENT PROGRAMS AND RESOURCES THAT ALIGN WITH MILLION HEARTS®

**Cheryl Farmer, MD**
*Manager, Heart Disease, Stroke, and Diabetes Prevention Program*
*Community-Based Prevention Section, Washington State Department of Health*

**Susan S. Buell**
*Association Director of Adult Healthy Lifestyles and Chronic Disease*
*YMCA of Pierce and Kitsap Counties*

Washington State Department of Health

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PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND HEALTHIER COMMUNITY

Washington State Department of Health

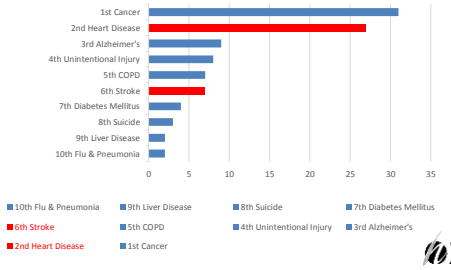
## Heart Health: The Landscape of Washington State

Heart Disease, Stroke, and Diabetes Prevention Program
Community-Based Prevention Section

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND HEALTHIER COMMUNITY

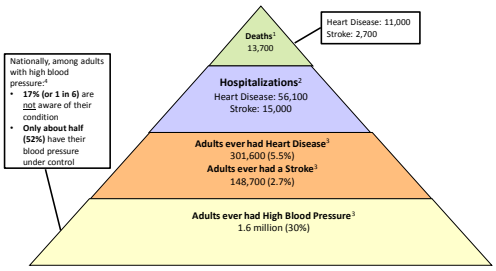
## 2015 Washington State 10 Leading Causes of Death

- Heart Disease and Stroke combined are the #1 cause of death in Washington State



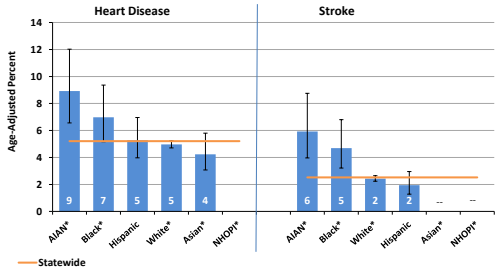

Health

### Burden of Heart Disease and Stroke In Washington State



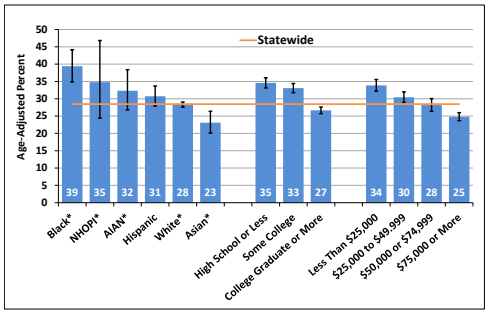

Sources: 1. Washington State Death Certificate Data, 2015. 2. Washington Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS) and Oregon State Hospital Discharge Data , 2014 (primary diagnosis listed, including both inpatient and observation cases). 3. Washington State Behavioral Risk Factor Surveillance System (BRFSS) Survey Data, 2015 (self-reported, among adults 18+ years). 4. National Health and Nutrition Examination Survey, 2011-2012. (controlled: systolic blood pressure below 140 mm Hg and diastolic blood pressure below 90 mm Hg).

### Heart Disease and Stroke By Race and Hispanic Origin




Source: Washington State Behavioral Risk Factor Surveillance System Survey, 2013-2015.
Abbreviations: AIAN, American Indian/Alaska Native; NHOPI, Native Hawaiian/Other Pacific Islander. *Non-Hispanic, single race only. -- Sample too small to obtain reliable estimates.
Note: Among adults 18 years and older.

### Disparities in Self-Reported High Blood Pressure




Source: Washington State Behavioral Risk Factor Surveillance System Survey, 2013 and 2015 combined.
Abbreviations: AIAN, American Indian/Alaska Native; NHOPI, Native Hawaiian/Other Pacific Islander. *Non-Hispanic, single race only.
Note: Hypertension awareness by education among adults ≥25 years.

## What Are We Doing?

- **DP13-1305 and DP14-1422 CDC funded grants**
  - **Promoting awareness** of the importance of blood pressure control
  - **Leverage partnerships** to address the chronic condition of hypertension
  - We work with a variety of individuals, organizations, and communities to **offer in-person trainings** on how to accurately measure blood pressure
  - **Provide educational materials** in multiple languages to support blood pressure management and control
  - **Connect communities** to available resources

## Thank You!

Cheryl Farmer MD
Washington State Department of Health
Heart Disease, Stroke, and Diabetes Prevention Program
cheryl.farmer@doh.wa.gov | 360-236-3770

the YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

## COMMUNITY COLLABORATION TO REDUCE HYPERTENSION

YMCA BLOOD PRESSURE SELF-MONITORING PROGRAM

COLLABORATION WITH CHWs, MERCY HOUSING, ASIAN PACIFIC CULTURAL CENTER

## THE Y'S NATIONAL MILLION HEARTS® COMMITMENT

The Y has been committed to the Million Hearts Initiative since 2011.

**The Y Joins CDC, HHS and CMS in Million Hearts Initiative**

*YMCA of the USA announces commitment to expand efforts to help reduce heart disease and stroke*

**CHICAGO, September 13, 2011** – The Y announced its support of the Million Hearts Initiative – an initiative spearheaded by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and Centers for Medicare and Medicaid Services that aims to prevent one million heart attacks and strokes over the next five years – at an event today in Washington, D.C.

## CURRENT YUSA STRATEGIC PLAN

**HEALTHY LIVING**
**Improving the Nation's Health and Well-Being**

**CRITICAL SOCIAL ISSUES AFFECTING OUR COMMUNITIES:**
- High rates of chronic disease and obesity (child and adult)
- Needs associated with an aging population
- Health inequities among people of different backgrounds

**OUR SHARED INTENT:**
To improve lifestyle health and health outcomes in the U.S., the Y will help lead the transformation of health and health care from a system largely focused on treatment of illnesses to a collaborative community approach that elevates well-being, prevention, and health maintenance.

**OUR DESIRED OUTCOMES:**

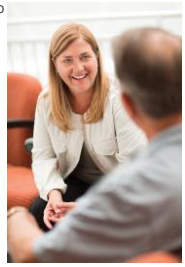
| | | | | |
|---|---|---|---|---|
| People achieve their personal health and well-being goals. | People reduce the common risk factors associated with chronic disease. | The healthy choice is the easy, accessible, and affordable choice, especially in communities with the greatest health disparities. | Ys emphasize prevention for all people, whether they are healthy, at-risk, or reclaiming their health. | Ys partner with the key stakeholders who influence health and well-being. |

## HEALTHY LIVING AT THE Y


## BLOOD PRESSURE SELF-MONITORING (BPSM) PROGRAM OVERVIEW

4 month evidence-based program designed to help persons with high blood pressure better manage their blood pressure by developing the habit of self-monitoring:

- Guidance and tools for self-monitoring and tracking
- Healthy Heart Ambassador support via weekly Office Hours and messages
- Monthly Nutrition Education Seminars
- Data collected and managed in customized online database (REDCap)



## THE YMCA PRODUCED SLIGHTLY MORE FAVORABLE FINDINGS THAN THOSE REPORTED IN THE CHECK IT, CHANGE IT STUDY.

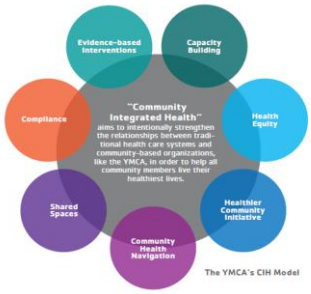
| "Check It, Change It" Study (n=1,784) | YMCA (n=526) |
|---|---|
| At baseline, 49.3% of participants had a BP <140/90 mmHg. | At baseline, 51.7% of participants had a BP <140/90 mmHg. |
| By 6 months, 74% of participants either reached a BP <140/90 mmHg or had a ≥10 mmHg reduction in SBP. | After an average of 4.3 months, 75.1% of participants either reached a BP <140/90 mmHg or had a ≥10mmHg reduction in SBP. |
| Overall, mean SBP decreased by 4.8 mmHg. | Overall, mean SBP decreased by 6.3 mmHg. |
| Overall, mean DBP decreased by 2.5 mmHg. | Overall, mean DBP decreased by 3.2 mmHg. |

"Check It, Change It" enrolled patients from 8 clinics in Durham County, NC between 12/09/2010 and 11/11/2011.

## THE YMCA'S BLOOD PRESSURE SELF-MONITORING PROGRAM

| | |
|---|---|
| Who? | • Adults with high blood pressure and/or on antihypertensive medication<br>• Interested in self-monitoring<br>• No recent cardiac events, no atrial fibrillation/arrhythmias, no risk for lymphedema |
| What? | • **4 month program** supporting participants in developing the habit of self-monitoring and identifying opportunities for action through weekly support & 10-minute consultations<br>• Nutrition and physical activity information to aid in blood pressure control through lifestyle change |
| When? Where? | • Anytime, anywhere (lobby, clinic, multipurpose space)<br>• Space for blood pressure stations and nutrition education seminars; adequate privacy<br>• Many non-YMCA sites; workplaces, clinics, community centers |
| How? | Training on proper blood pressure measurement technique<br>Ongoing support, education and coaching from trained staff<br>Tools for self-monitoring and tracking<br>Weekly messages, drop-in consultations, and seminars |

## PARTICIPATING IN COMMUNITY INTEGRATED HEALTH




## REDUCING HYPERTENSION RISK WITH HEALTH EQUITY THROUGH COLLABORATION

- Through the support of 1422 funding, the YMCA is able to deliver the Blood Pressure Self-Monitoring Program (BPSMP) at community sites
- Community partners were pulled together to test this delivery model:
  - Leaders in Women's Health
  - Ebony Nurses
  - Samoan Nurses Association of WA
  - Mercy Housing Northwest
  - Asian Pacific Cultural Center
  - YMCA of Pierce and Kitsap Counties
  - Tacoma Pierce County Health Department

## REDUCING HYPERTENSION RISK WITH HEALTH EQUITY THROUGH COLLABORATION

- 5 Community Health Workers representative of the communities they serve were trained by the YMCA in the delivery of the evidence-based BPSMP under the YMCA license. Many languages were represented in the delivery of the program:
  - Spanish
  - Vietnamese
  - Samoan
  - English
- Through those trusted relationships with CHWs, we were able to enroll 171 participants with hypertension living in federally qualified low income housing and/or who are participants at the Asian Pacific Cultural Center

## YMCA/CHW COLLABORATION TO DELIVER BLOOD PRESSURE SELF-MONITORING PROGRAM

**PROGRAM OUTCOMES: YMCA of Pierce and Kitsap Counties Pilot**

| | Mercy Housing | Asian Pacific Cultural Center | Morgan Family YMCA |
|---|---|---|---|
| Total Participants | 144 | 27 | 16 |
| % of participants who completed 4 month program with decrease in systolic BP | 53.4% | 29% | 25% |
| Overall mean decrease in systolic BP | 16.3 | 28.8 | 8.75 |

In the original "Check It, Change It" study that demonstrated this program as an effective strategy, the overall mean systolic blood pressure decrease after a 6 month intervention was 4.8. In the YMCA of USA pilot, the overall mean SBP decrease after a 4.3 month intervention was 6.3. In the YMCA of PKC pilot, our community-partnered intervention well outperformed the original studies as evidenced in the chart above.

## YMCA/CHW COLLABORATION TO DELIVER BLOOD PRESSURE SELF-MONITORING PROGRAM

- New cohort for Koreans began in July 2017 (50 enrolled to date)
- On-going commitment to run the BPSMP through October of this year
- Exploring sustainability strategies for continued delivery of the BPSMP with CHWs in 2018

## HOW YOU CAN HELP

- Help to champion program among health care provider groups and stakeholders in the community
- Provide direct program referrals to eligible patients
- Add program to community-based resource directory
- Post/distribute marketing materials to raise program awareness.
- Donate space for program sessions
- Help identify sustainable funding opportunities for the delivery of this program to improve health outcomes for high utilizing patients

## EHR REFERRAL EXAMPLE


# THANK YOU

Susan Buell
Association Director Adult Healthy Lifestyles and Chronic Disease
sbuell@ymcapkc.org | 253-460-8912

# Q & A

## Group Interaction

# QUALIS HEALTH PROGRAMS AND RESOURCES THAT ALIGN WITH MILLION HEARTS®

**Jeff Sobotka, PMP, MBA, CPHIMS, CHP**
*Quality Improvement Consultant, Practice Coach, Qualis Health, Healthy Hearts Northwest Project*

# Qualis Health QIN-QIO

**Jeff Sobotka**
**Lisa Packard**

August 10, 2017

Qualis Health

- A leading national population health management organization
- The Medicare Quality Innovation Network - Quality Improvement Organization (QIN-QIO) for Idaho and Washington

The QIO Program

- One of the largest federal programs dedicated to improving health quality at the local level

## Qualis Health and QI Projects in Healthcare

**Think of the Triple Aim**

- Improve patient experience
  - Healthcare processes and outcomes
    - Surgical or disease specific improvement; improving blood pressure control; patient satisfaction; improving readmission rates, etc.
- Improve population health
    - Chronic condition management in a population; vaccination rates; nutrition; anti-smoking efforts; use of preventive care services
- Reduce costs through quality
    - Improve efficiency, staff stability etc.

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## IHI Model for Improvement


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## Qualis and Cardiovascular Risk Prevention

**Healthy Hearts Northwest**

Funded through the Agency for Health Care Research & Quality (AHRQ) - Healthy Hearts Northwest (H2N) is one of seven national grant awards

Healthy Hearts Northwest Partners:

- The MacColl Center for Health Care Innovation at Group Health Research Institute
- Qualis Health – Subcontractor
- Scheduled to Complete Q1 2018

**Qualis Health's Practice Innovation Network (PIN)**

- Assists Washington primary care practices to develop quality improvement processes and related reports to help them prepare for value-based reimbursement and improve cardiac care

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## Healthy Hearts Northwest

- Unlimited customized technical assistance including on-site practice visits for 15 months, and monthly phone calls
- Quality Improvement reports for internal use, aligned with PQRS measures
- Optimization of clinical decision support
- Using data to drive improvement through workflow changes
- Clinically focused learning modules for care teams to address common issues in CVD population management
- Data Submission
- PDSA, Webinars, IHI Model for Improvement

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## Healthy Hearts Northwest

- Dissemination and Implementation of patient-centered outcomes research findings for small to medium size practices
- Build Capacity to use the ABCS of cardiovascular disease prevention:
    - (A) Aspirin in high-risk individuals
    - (B) Blood pressure control
    - (C) Cholesterol management
    - (S) Smoking cessation
- Adopt foundational PCMH concepts:
    - Quality Improvement
    - Leadership
    - Empanelment
    - Team-Based Care

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## Qualis' Practice Innovation Network (PIN)

- Qualis Health's Practice Innovation Network (PIN) is assisting Washington primary care practices to develop quality improvement processes and related reports to help them prepare for value-based reimbursement
  - Help all practices improve cardiac care
  - Educational webinars
  - Share pertinent information from CDC, CMS, etc.
  - Focus on ABCS measures
  - Higher level of attention
  - QI consulting
  - CMS evaluation metric based on PIN practices' scores for blood pressure and smoking

The goal of the Qualis PIN is to see each participating practice, organization, and the PIN as a whole improve performance on the selected quality measures

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## What do we ask of the PIN practices?

Share quality data on quarterly basis (Rolling 12 month)

- ABCS measures (Cardiovascular Prevention)
- Seasonal flu and pneumonia measures (correspond to F.1 adult immunizations)
- Key metrics related to diabetes (related to B.2 diabetes)
  - Hemoglobin A1c poor control
  - Diabetes eye exam
  - Diabetes foot exam

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## What does Qualis Health do with the data?

- Track our progress toward CMS evaluation metrics
- Identify areas for improvement at PIN practices
  - Help them stay on track for successful quality reporting
  - Identify practices/populations that might benefit from DSMP
- Produce quarterly benchmark reports - created to allow PIN participants to view their own data in relation to that submitted by the rest of the cohort as well as against National averages.
- The ultimate goal of the Qualis PIN is to see each participating practice, organization, and the PIN as a whole improve performance on the selected quality measures

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QUALIS HEALTH
PRACTICE INNOVATION NETWORK

Quarterly Benchmark Report

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### Measures Included in this Report:

1. QID 204 (NQF 0068) Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
2. **QID 236 (NQF 0018) Hypertension: Controlling High Blood Pressure**
3. **QID 226 (NQF 0028) Tobacco Use: Screening and Cessation Intervention**
4. QID 110 (NQF 0041) Influenza Immunization
5. QID 111 (NQF 0043) Pneumonia Vaccination Status for Older Adults
6. QID 1 (NQF 0059) Diabetes: Hemoglobin A1c Poor Control
7. QID 117 (NQF 0055) Diabetes: Eye Exam
8. QID 318 Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed: AND Risk-Stratified Fasting LDL-C

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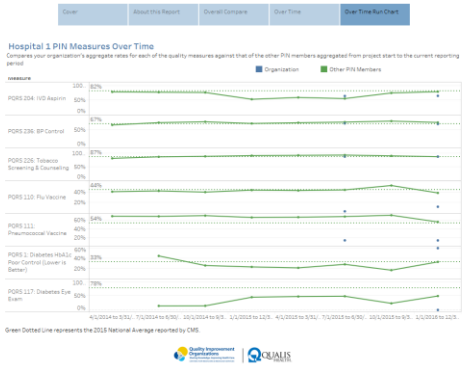


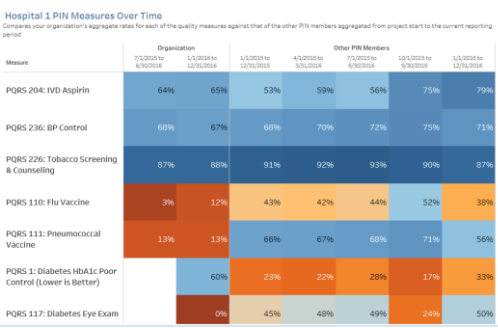


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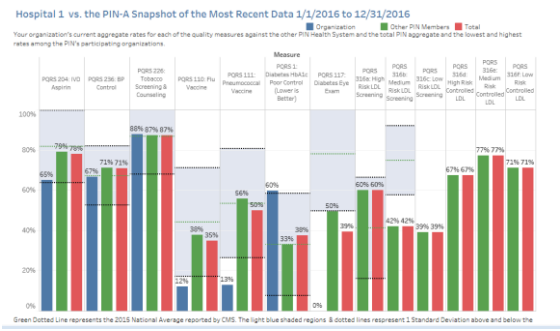




## Qualis Health and QPP/MIPS

Qualis Health's goal is to help practices successfully prepare for and understand this new program. We offer customized technical assistance that includes:

- Phone and email support
- Regular office hours and webinars
- Monthly program updates
- Access to Qualis Health Tracking tool
- Qualis Health QPP Readiness Assessment
- Strategic development of a MIPS feedback report
- Assistance in creating a MIPS-score improvement plan
- Virtual focus groups and peer-to-peer learning
- Access to national learning events

Check out our QPP resource center:

http://medicare.qualishealth.org/projects/QPP-resource-center



## Contact

**Lisa Packard, MS**
**QI Consultant**
**CDSME Master Trainer**
**LisaP@QualisHealth.org**

**Jeff Sobotka, PMP, MBA, CPHIMS, CHP**
**Quality Improvement Consultant**
**Practice Coach**
**Healthy Hearts Northwest Project**
**JeffS@QualisHealth.org**

*For more information:*
http://medicare.qualishealth.org/

This material was prepared by Qualis Health, the Medicare Quality Innovation Network - Quality Improvement Organization (QIN-QIO) for Idaho and Washington, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.
ID/WA-HITC-QH-3064-08-17.



Million Hearts®

## Q & A

## AHA/ASA PROGRAMS AND RESOURCES THAT ALIGN WITH MILLION HEARTS®

### Western States Affiliate

**Lindsay Hovind**
*Senior Director, Government Relations*

**Elaine Kitamura**
*Regional Director, Multicultural Initiatives*

**Kristen VanWart**
*Sr. Community Health Director, Field Operations/Development*

**Elizabeth Peterson**
*Regional Director, Quality & Systems Improvement*

American Heart Association.
life is why™

## AHA/ASA PROGRAMS AND RESOURCES THAT ALIGN WITH MILLION HEARTS®

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## Mission

Building healthier lives, free of cardiovascular disease and stroke

## Our 2020 Impact Goal

By 2020 to improve the cardiovascular health of all Americans by 20% while reducing deaths from cardiovascular diseases and stroke by 20%

## Lindsay Hovind

**Senior Director, Government Relations**

## AHA and Million Hearts Spotlight on Washington: Advocacy

Recent Policy successes:

- Emergency Cardiac and Stroke System of Care (2010)
- CPR in Schools (2013)
- Newborn Screening for CCHD (2015)
- Historic investments in Safe Routes to School (2015)
- PE Quality Assessment (2017)
- Seattle Sugary Drink Tax (2017)

## AHA and Million Hearts Spotlight on Washington: Advocacy

Future Policy Priorities:

- Nutrition, physical activity, screen time standards in early child care settings
- Tobacco to 21
- Tobacco Prevention Program Funding
- Expansion of SNAP incentives
- Emergency of Cardiac and Stroke System of Care enhancemer

## Elizabeth Peterson

**Regional Director, Quality & Systems Improvement (QSI)**

## AHA and Million Hearts Spotlight on Washington: QSI

- Improve medical care and education of patients
- Initiation of and adherence to evidence-based, guideline-recommended therapies
- Collection of data to improve quality of care in the hospital and for research
- Celebrate successes


## Kristen VanWart

**Senior Director, Community Health**

## AHA Workplace Health Solution

- Workplace Health Solutions programs provides organizations with science based tools to help them get the most of curren wellness program and/or activities
- The program provides continuous quality improvements by assessing current wellness programs, giving companies the ability to engage employees, track their ideal heart health and gives the organizations the opportunity to be recognized through awards

## Workplace Health Achievement Index

- 55 process questions completed online organized around seven best practice categories. Receive a report on total overall score, score for each best practice category
  - Leadership
  - Policies and environment
  - Communications
  - Programs
  - Engagement
  - Partnerships
  - Reporting outcomes

## Workplace Health Achievement Index

- Data insight based on health analytics
- Data can be imported into the online platform by employer if they have existing data or they can choose to use the American Heart Association's My Life Check health assessment

## Resources and Tools to Enhance Workplace Health

- Complete Workplace Health Solutions Index
- Detailed Playbooks for all 7 best practice categories within Workplace Health Solutions
- My Life Check Health Assessment
- Check, Change, Control: Blood Pressure
- Food and Beverage Tool Kit for a healthy food environment and policies


## Elaine Kitamura

**Regional Director, Multicultural Initiatives**

## What is Target BP

- A call to action motivating medical practices, practitioners and health services organizations to prioritize blood pressure control
- Recognition for healthcare providers who attain high levels of blood pressure control in their patient populations, particularly those who achieve 70, 80 percent or higher control
- A source for tools and assets for healthcare providers to use in practice, including the AHA/ACC/ CDC, Hypertension Treatment Algorithm and the AMA's M.A.P. Checklist

TARGET:BP | AMA

http://targetbp.org/

## Who is our Target Audience?

- Primary Care System
  - Federally Qualified Health Clinic (FQHC)
  - Federally Designated Rural Health Clinic (RHC)
  - Indian Health Service practice/clinic
  - Practice/Clinic with mission to serve publicly insured, under or uninsured
  - Private Clinical System (non-FQHC)
- Government Agency or Organization providing care to patients

TARGET:BP | AMA

## Why should a clinic participate?

- We know what medicines work but system aren't in the place to drive control rates
- Algorithm and systems approach described in AHA's treatment algorithm have been shown to increase control rates within a clinical setting
- Sites will receive recognition from AHA
- Help meet required performance metric
- Improved health and care of their patients!

TARGET:BP | AMA

http://targetbp.org/

## Levels of Recognition

- Here will be two levels of recognition in 2017:
  - Achievement: 70% of patients with blood pressure controlled to <140/90 in 2016.
  - Participation: Recognizes health care systems for registering with Target: BP and submitting data.

TARGET:BP | AMA

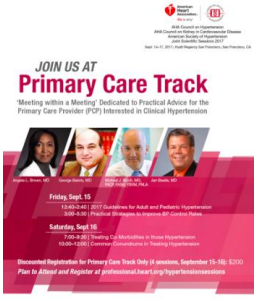
http://targetbp.org/

## Data Submission

- Data will be submitted once a year during a set period of time.
- During 2017 this period of time is set between March and July to report on 2016 data.
- Participants will be notified of recognition status by October 2017.

TARGET:BP | AMA

http://targetbp.org/



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## Q & A

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## CATERED LUNCH

Resume at 12:20

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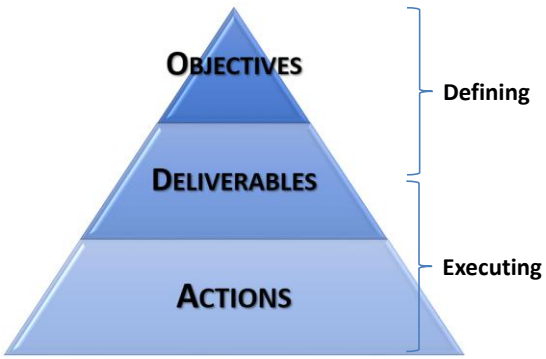
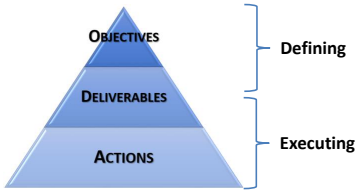
## AFTERNOON BREAKOUTS / FACILITATED DISCUSSIONS

**John Bartkus, PMP, CPF**
*Principal Program Manager, Pensivia*

Workgroup Approach




Workgroup Approach

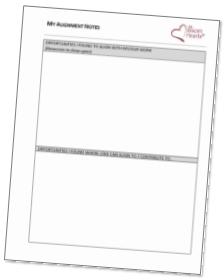



Define the Destination

Plan the Route

Drive !

Use this Conversation
as a Vehicle to Identify & Cultivate Alignment.

## Afternoon Workgroup Meeting Rooms

| 1<br>Hypertension Control | 2<br>Role of Community Health Workers and Community… | 3<br>Worksite Wellness | 4<br>Public Health Policy - Advancing the ABCS |
|---|---|---|---|
| **Cheryl Farmer,**<br>**Elaine Kitamura,**<br>**Jeff Sobotka**<br>Miriam Patanian | **Marissa Floyd,**<br>**Alexandro Pow Sang,**<br>**Debbie Spink**<br>Julia Schneider<br>April Wallace | **Sara Eve Sarliker,**<br>**Kristen VanWart**<br>Julie Harvill<br>Mary Jo Garofoli | **Lindsey Hovind**<br>Robin Rinker<br>Whitney Garney |
| **Everett**<br>Suite | **Olympia**<br>Suite | **Evergreen**<br>Ballroom<br>*(Here)* | **Renton**<br>Suite |

Workgroups have until 2:00pm. At 2:10pm, Report-Outs Start!

Million Hearts®

## REPORTS FROM WORKGROUPS AND PLANS FOR FOLLOW-UP

**John Bartkus, PMP, CPF**
*Principal Program Manager, Pensivia*

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## EVALUATION AND FEEDBACK PROCESS

**Whitney R. Garney**
*WRG Consulting*

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## WRAP UP & ADJOURN

**April Wallace**
*Program Initiatives Manager, Million Hearts® Collaboration*