Advancing Million Hearts®: AHA and State Heart Disease and Stroke Partners Working Together in South Dakota

July 11, 2017
9:00 AM to 3:00 PM CT

Holiday Inn, Sioux Falls City Centre
100 W. 8th St.
Sioux Falls, South Dakota

Welcome & Overview of the Day

Julie Harvill, Operations Manager
Million Hearts® Collaboration

John Clymer, Executive Director
National Forum for Heart Disease and Stroke Prevention
Co-Chair, Million Hearts® Collaboration

Expectations-Approach for the Day

John Bartkus, *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 Breakouts

1 IMPROVE DATA COLLECTION	2 PRIORITY POPULATIONS	3 CONTINUUM OF CARE	4 PREVENTION & MANAGEMENT
Ashley Miller Stan Kogan Whitney Garney Robin Rinker Mallory Stasko	**Kiley Hump** Julia Schneider April Wallace Linda Stopp	**Megan Myers** Julie Harvill Mary Jo Garofoli	**Katie Hill** Miriam Patanian John Clymer Holly Arends

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

A key focus for the day…

ALIGNMENT

Activity

- "We're all Arrows"
- Look around the room.
  Identify something to focus on.
- Close your eyes.
- Fully extend your arm to point at it.
  (Watch out for your neighbors)

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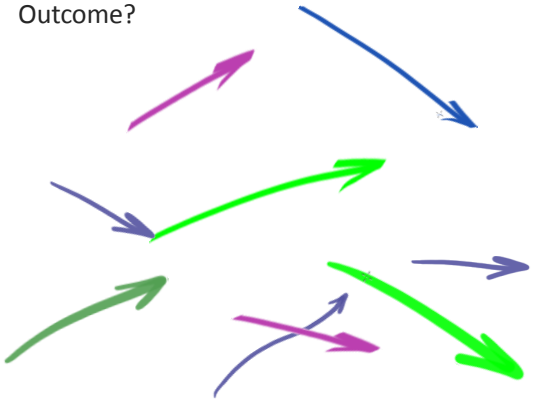
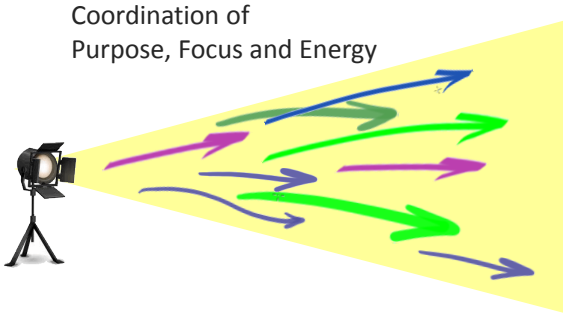
Outcome?



Alignment

Coordination of
Purpose, Focus and Energy



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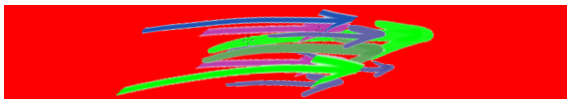
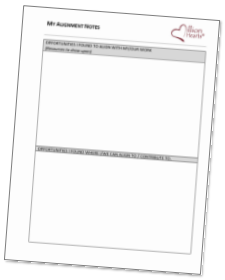


Higher Impact on the target

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

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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

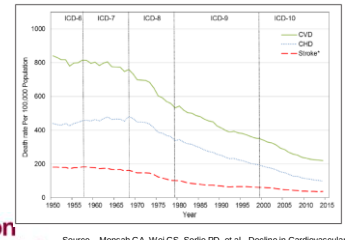
Heart Disease and Stroke in the U.S.

- 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]

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

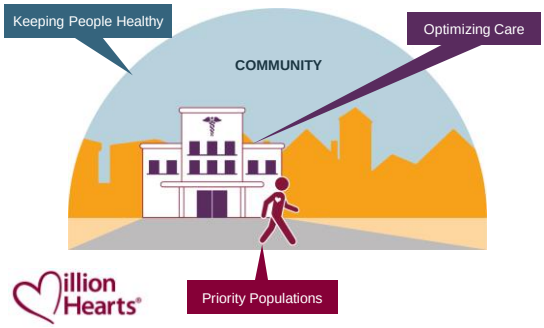
Heart Disease and Stroke Trends 1950-2015

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



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

Keeping People Healthy

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

Optimizing Care

Goals	Effective Health Care Strategies
Improve ABCS* Targets: 80% **Increase Use of Cardiac Rehab** Target: 70% **Engage Patients in Heart-healthy Behaviors** Targets: TBD	***High Performers Excel in the Use of…*** • **Teams**—including pharmacists, nurses, community health workers, and cardiac rehab professionals • **Technology**—decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care • **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

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

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Improving Outcomes for Priority Populations

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

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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

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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

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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

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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

Q & A

Group Interaction

Break

SOUTH DAKOTA DEPARTMENT OF HEALTH

KILEY HUMP, ADMINISTRATOR
OFFICE OF CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

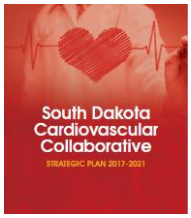
DOH STRATEGIC PLAN 2015-2020

VISION	Healthy People Healthy Communities Healthy South Dakota
MISSION	To promote, protect and improve the health of every South Dakotan
GUIDING PRINCIPALS	Serve with integrity Eliminate health disparities Demonstrate leadership and accountability Focus on prevention and outcomes Leverage partnerships Promote innovation

GOOD & HEALTHY SOUTH DAKOTA

OFFICE OF CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

The Cardiovascular Collaborative



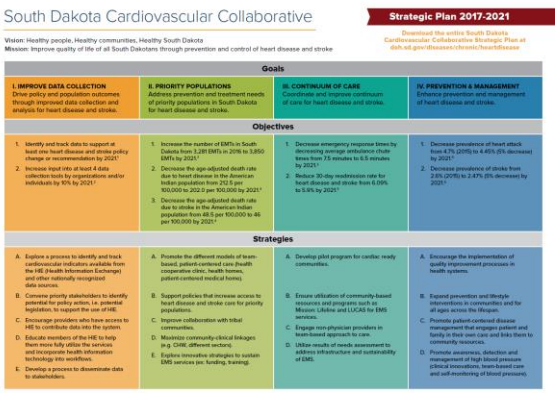
A group of medical and public health representatives who want to improve the quality of life for all South Dakotans through prevention and control of heart disease and stroke.

Leadership Team

- Holly Arends
- Kevin Atkins
- Mandi Atkins
- Stacie Davis
- Mark East
- Colette Hesla
- Katie Hill
- Kiley Hump
- Amanda Keefe
- Marty Link
- Mary Michaels
- Ashley Miller
- Megan Myers

*Have a conference call quarterly

Collaborative Planning Process


South Dakota Cardiovascular Collaborative

Strategic Plan 2017-2021

Vision: Healthy people, Healthy communities, Healthy South Dakota

Mission: Improve quality of life of all South Dakotans through prevention and control of heart disease and stroke

Goals

I. IMPROVE DATA COLLECTION	II. PRIORITY POPULATIONS	III. CONTINUUM OF CARE	IV. PREVENTION & MANAGEMENT
Drive policy and population outcomes through improved data collection and analysis for heart disease and stroke.	Address prevention and treatment needs of priority populations in South Dakota for heart disease and stroke.	Coordinate and improve continuum of care for heart disease and stroke.	Enhance prevention and management of heart disease and stroke.

Objectives

1. Identify and track data to support at least one heart disease and stroke policy change or recommendation by 2021. 2. Increase input into at least 4 data collection tools by organizations and/or individuals by 10% by 2021.	1. Increase the number of EMTs in South Dakota from 3,281 EMTs in 2016 to 3,850 EMTs by 2021. 2. Decrease the age-adjusted death rate due to heart disease in the American Indian population from 212.5 per 100,000 to 202.0 per 100,000 by 2021. 3. Decrease the age-adjusted death rate due to stroke in the American Indian population from 48.5 per 100,000 to 46 per 100,000 by 2021.	1. Decrease emergency response times by decreasing average ambulance chute times from 7.5 minutes to 6.5 minutes by 2021. 2. Reduce 30-day readmission rate for heart disease and stroke from 6.69% to 5.9% by 2021.	1. Decrease prevalence of heart attack from 4.7% (2015) to 4.45% (5% decrease) by 2021. 2. Decrease prevalence of stroke from 2.6% (2015) to 2.47% (5% decrease) by 2021.

Strategies

A. Explore a process to identify and track cardiovascular indicators available from the HIE (Health Information Exchange) and other nationally recognized data sources. B. Convene priority stakeholders to identify potential for policy action, i.e. potential legislation, to support the use of HIE. C. Encourage providers who have access to HIE to contribute data into the system. D. Educate members of the HIE to help them more fully utilize the services and incorporate health information technology into workflows. E. Develop a process to disseminate data to stakeholders.	A. Promote the different models of team-based, patient-centered care (health cooperative clinic, health homes, patient-centered medical home). B. Support policies that increase access to heart disease and stroke care for priority populations. C. Improve collaboration with tribal communities. D. Maximize community-clinical linkages (e.g. CHW, different sectors). E. Explore innovative strategies to sustain EMS services (ex: funding, training).	A. Develop pilot program for cardiac ready communities. B. Ensure utilization of community-based resources and programs such as Mission: Lifeline and LUCAS for EMS services. C. Engage non-physician providers in team-based approach to care. D. Utilize results of needs assessment to address infrastructure and sustainability of EMS.	A. Encourage the implementation of quality improvement processes in health systems. B. Expand prevention and lifestyle interventions in communities and for all ages across the lifespan. C. Promote patient-centered disease management that engages patient and family in their own care and links them to community resources. D. Promote awareness, detection and management of high blood pressure (clinical innovations, team-based care and self-monitoring of blood pressure).

Year 1 Implementation

- In-person Action Planning meeting March 2017
- Selected Year 1 Priority Strategy in each goal area
- Workgroup calls
- Advancing Million Hearts Conference

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Q & A

Group Interaction

Improving Cardiac Care- the Great Plains States

Holly Arends, Program Manager
South Dakota Foundation for Medical Care

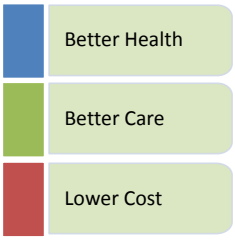
Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains Quality Innovation Network

Great Plains Quality Innovation Network (GPQIN)

- Antibiotic Stewardship
- Cancer Prevention
- Cardiac Health
- Care Coordination
- Diabetes Care
- Healthcare Infections
- Immunizations
- Medication Safety
- Nursing Home Care
- Quality Payment Program
- Transforming Clinical Practice
- Colorectal Cancer Screening

Triple AIM Approach to Clinical Quality



Foundation Principles:

- Enable innovation
- Foster learning organizations
- Eliminate disparities
- Strengthen infrastructure and data systems

Our Approach

- Align with the Million Hearts® Initiative (www.millionhearts.hhs.gov) to improve preventive care measures, including aspirin use, blood pressure control, cholesterol management and smoking/tobacco education
- We will target disparate populations, including gender, racial and ethnic disparities and rural, to improve cardiac health

Our Approach

- Focus on the ABCS
  - Measure monitoring
    - HHQI
    - MIPS Calculator
    - Practice Pattern Variance
  - Data driven QI
  - Optimizing utilization of HIT
  - Support innovations in care delivery

Cardiovascular Health and Million Hearts®

Our planned improvement efforts align with the national Million Hearts® initiative that seeks to prevent one million heart attacks and strokes by 2022.

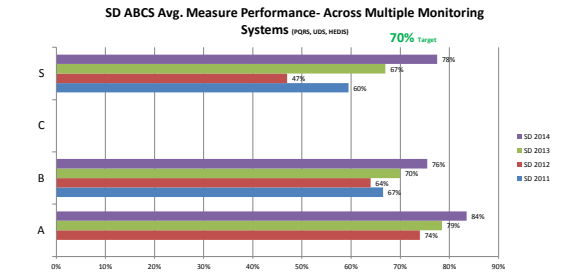
- Heart disease and stroke are the first- and fourth-leading causes of death[1]
- Heart disease and stroke cost more than $312.6 billion in healthcare expenditures and lost productivity annually[2]

1. Centers for Disease Control and Prevention
2. Million Hearts®

Our Approach

- Offering technical assistance on the Physician Quality Reporting System (PQRS) cardiovascular measures submission for participating clinics
- Assist home health agencies with measures reporting through the Home Health Cardiovascular Data Registry
- Help clinics utilize EHRs for data analysis and performance improvement activities focused on clinical quality measures

South Dakota Performance



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This material was prepared the Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for Kansas, Nebraska, North Dakota and South Dakota, 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. 11SOW-GPQIN-GEN-01/0914

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Q & A

Overview of the American Heart Association and Programs and Resources that align with Million Hearts®

Megan Myers
SD Government Relations Director

American Heart Association | American Stroke Association
life is why

Mission

Building healthier lives, free of cardiovascular diseases 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%.

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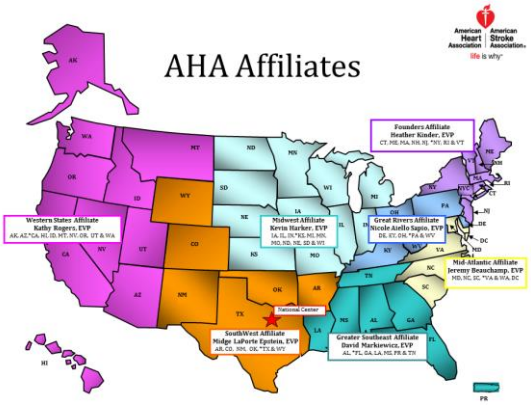
AHA Affiliates



Building a Culture of Health

A culture in which people live, work, learn, play and pray in environments that support healthy behaviors, timely quality care and overall well-being.

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AHA and Million Hearts® Spotlight on South Dakota

Quality & Systems Improvement Priorities

Get With The Guidelines & Mission: Lifeline Quality Awards

- Avera Heart Hospital of South Dakota
- Sanford USD Medical Center
- Rapid City Regional Hospital

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AHA and Million Hearts® Spotlight on South Dakota

Quality & Systems Improvement Priorities

2017 Mission: Lifeline EMS Recognition

- Paramedics Plus – Sioux Falls
  - Sioux Falls Fire Rescue
  - Sioux Falls Police
- Moody County Ambulance - Flandreau

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AHA and Million Hearts® Spotlight on South Dakota

Advocacy

- **Policy Goals**
  Organized by category, based on scientific research and modified each year based on latest data and how many people impacted
- **You're the Cure Network, SD Advocacy Committee**
  Grassroots advocacy network and statewide grasstops advocates

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AHA and Million Hearts® Spotlight on South Dakota

Advocacy Priorities

- Health Insurance Coverage – Medicaid Expansion/Reform
- Systems of Care – Stroke and STEMI Designations and Registries, Cardiac-Ready Communities
- Healthy Living – Complete Streets, Healthy SD
- Tobacco-Free – Smoke Free SD, Tobacco Prevention/Control

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CPR in Schools

- South Dakota was 36th state to require hands-only CPR in required curriculum before graduation
- Became law July 1, 2017
- Could train up to 10,000 students a year in bystander CPR and greatly enhance our emergency services capacity in South Dakota

Cardiac-Ready Communities

- Program designed to prepare communities to respond and assist to increase survival from a cardiac event occurring outside of the hospital setting
- North Dakota, Montana, Minnesota have similar programs, SD gathering best practices

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Healthy Living

- Support efforts to increase active living and healthy eating through policy
- Complete Streets, Safe Routes to School, bike safety laws
- Increasing quality and quantity of physical activity in schools
- Supporting school lunch standards

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Tobacco-Free

- Reduce tobacco use in South Dakota
- Increasing price of tobacco products – 2006
- Defending our smoke-free law – passed 2010
- Working to ensure the US Food and Drug Administration has the authority to regulate tobacco, including e-cigarettes
- Work annually in Pierre on enforcement and program funding

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1) Blood Pressure Strategies

Increase and sustain blood pressure control from 54% to over 70% through healthcare system participation in Target BP — **IMPACT:** 7-12.5M

Increase % of hypertensive patients that are self-monitoring through community and employer based SMBP programs *(Y-BP and CCC)* — **IMPACT:** 500K (Complementary)

Implement policy agenda to support increased hypertension control *(home monitor coverage, Y-BP coverage, etc.)*

Current Prevalence:

33 Million

Number of Adults 20+ with blood pressure >140/90 and/or BP medication use (NHANES 13-14)

Health Equity Priority Populations

- Highest prevalence: Black Adults (19% of total), Hispanic Adults (16% of total)
- Impact on Health Disparities: Twin approach focus on FQHCs and community clinics

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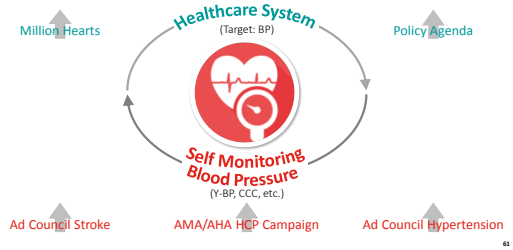
Blood Pressure Ecosystem



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American Heart Association. life is why
Check. Change. Control. CHOLESTEROL™

Nationally supported by Sanofi and Regeneron
& supporting the 2020 AHA/ASA Impact Goal,
Check. Change. ***Control.*** Cholesterol ™
will empower all Americans to better manage their cholesterol
through the knowledge, tools, and resources needed
to reduce their risk for cardiovascular disease.

National Supporter
SANOFI REGENERON

Objectives

- Increase adoption and utilization of cholesterol management guidelines through professional education and quality improvement programs.
- Increase understanding of and adherence to evidence-based treatment guidelines through public and patient education.

National Cholesterol Initiative Goals

- To set up a **pilot program in an Integrated Delivery Network with 50 healthcare providers** by summer 2018.
- Within the pilot program, achieve a 10% improvement in **clinical management** of cholesterol and a 10% improvement in **perceptions of self-management** of cholesterol in patients with **existing cardiovascular disease** (CVD) and patients **at high risk for CVD** by November 2018.

10% improvement in clinical management	10% improvement in perceptions of self-management
Sub-goal 1: Achieve a 10% increase in percentage of adult patients with existing atherosclerotic cardiovascular disease (ASCVD) or at high risk for the development of ASCVD who are prescribed statin therapy. (PQRS #438 + additional reporting for groups with ASCVD risk > 7.5%) **Sub-goal 2:** Achieve a 10% improvement in provider-reported utilization of lifestyle-based treatment practices for cholesterol management.	**Sub-goal 3:** Achieve a 10% improvement in self-reported patient outcomes focused on self-management of health conditions, including cholesterol.

- Concurrent to the pilot effort, prepare for **national population roll out** launching in Spring 2018.

2020 Goal & Plan Alignment: Based on the pilot settings, the Center for Health Metrics & Evaluation is advising on scenarios to extrapolate the potential for impact of this clinical management measure nationally. This will guide our national scale strategy in alignment with the 2020 goal measure (total cholesterol) and the 2017-2020 plan.

Public Awareness, Patient Engagement & Empowerment

Strategy: Increase public awareness, education and engagement of patients and family caregivers to improve understanding of cholesterol treatment and management.

Actions Taken:

- ✓ Conducted market research with patients to understand gaps in perceived understanding and knowledge to inform educational efforts, as well as to identify news hooks for media launch, ongoing media outreach and new content.
- ✓ Planning is underway for consumer education campaign launch.
- ✓ Conducted content audit of Heart.org/Cholesterol and began refresh of content and tools.

Next Steps:

- Release refreshed content on Heart.org/Cholesterol in April 2017.
- Conduct consumer media campaign launch and begin continuous outreach via owned, earned and paid media channels in April 2017.
- Conduct Public Health Summit on April 11th 2017.
- Develop post-summit action plan, distribute to summit participants and conduct ongoing follow-up with participants to inform future efforts and further reach and impact of the initiative.

Strategic Approach

Public Health Summit: Convene thought-leaders to discuss gaps in care to drive better cholesterol management.

Increase adoption and utilization of treatment guidelines through quality improvement programs and professional education.

Increase understanding of and adherence to evidence-based treatment guidelines through public and patient awareness and education.

Quality Improvement & Professional Education

- eCQM & PROM development
- Pilot measures and quality improvement program in an Integrated Delivery Network
- National rollout of measures and quality improvement program
- Continuing education

Public Awareness & Patient Education/Empowerment

- Informed by patient and provider market research
- Awareness and educational messages deployed via a robust campaign

Tools and Resources

Online Tools

- My Life Check
- Heart Attack Risk Calculator
- AHA's Smoking Cessation Tools and Resources
- AHA Healthy Workplace Food and Beverage Toolkit July 2016

Resources

- EmPowered to Serve
- Get With The Guidelines
- Check.Change.Control
- Target: BP

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Discussion

1. Is there a program you were unaware of that you would like to explore further for implementation or application in the state?
2. On which topics would you like additional information?
3. Other questions

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Contact Information

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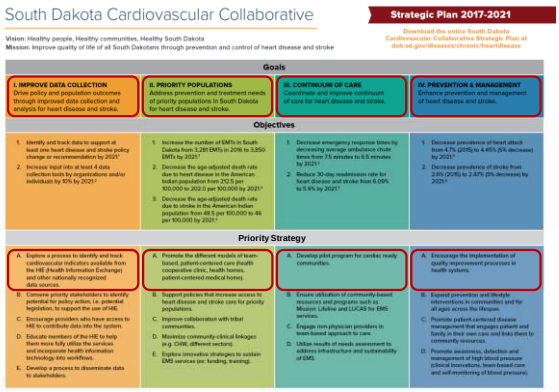
  - @MeganAtHeart
- Pam Miller, Regional Grassroots Advocacy Director
  - Brookings
  - 605-310-3170
  - pamela.miller@heart.org

Facebook.com/southdakotaheart

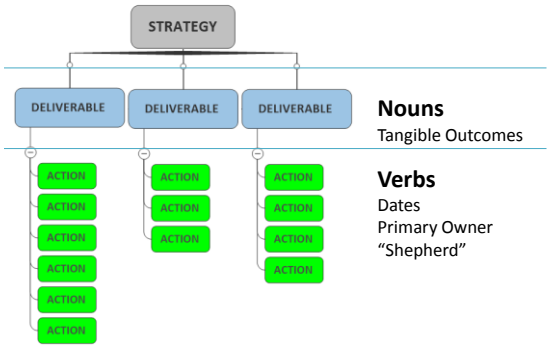
@sdakotaheart

70



Workgroup Approach

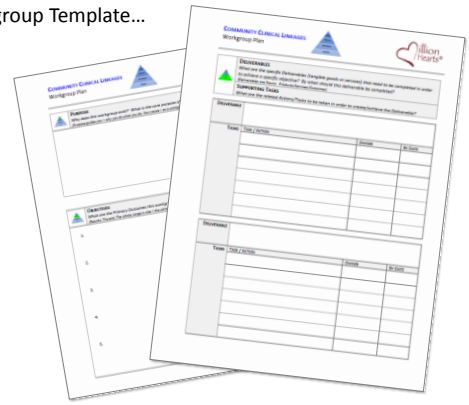
Workgroup Approach



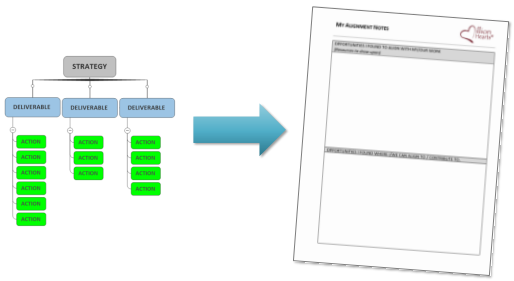
Nouns
Tangible Outcomes

Verbs
Dates
Primary Owner
"Shepherd"

Workgroup Template…



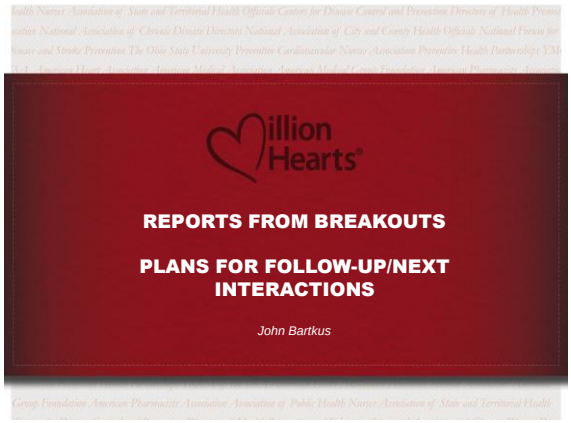
Use this Conversation about an Action Plan as a Vehicle to Identify & Cultivate Alignment.



Final Logistics –for Afternoon Breakouts

1 IMPROVE DATA COLLECTION	2 PRIORITY POPULATIONS	3 CONTINUUM OF CARE	4 PREVENTION & MANAGEMENT
Ashley Miller Stan Kogan Whitney Garney Robin Rinker Mallory Stasko	**Kiley Hump** Julia Schneider April Wallace Linda Stopp	**Megan Myers** Julie Harvill Mary Jo Garofoli	**Katie Hill** Miriam Patanian John Clymer Holly Arends

2:00pm – Groups provide "Report Outs" to the full team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REPORTS FROM BREAKOUTS
PLANS FOR FOLLOW-UP/NEXT INTERACTIONS
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Whitney R. Garney, WRG Consulting


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WRAP UP
April Wallace, Program Initiatives Manager, Million Hearts® Collaboration
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