

**Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention**

**Partners Working Together in Kentucky**

**July 11, 2018**



**Frankfort, Kentucky**

*Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in Kentucky* was a guest presentation during the **Kentucky Heart Disease and Stroke Prevention Task Force** on July 11, 2018 in Frankfort, Kentucky at the Berry Hill

**Guest Presentation – Million Hearts® 2022**

Jill Birnbaum, April Wallace, Julie Harvill – AHA, Million Hearts® Collaboration  
Janet Wright, MD, Million Hearts® Executive Director

- Focus on Alignment
- Million Hearts® Accomplishments
- What must happen to prevent?
- 2018 Focus
- Q and A/Group Interaction

**Addressing Priorities, Work and Resources that align with Million Hearts®**

Kentucky Department for Public Health

- Connie White, MD, Senior Deputy Commissioner
- Amy Graham, AHA, Quality & Systems Improvement Director

American Heart Association

- Tonya Chang, AHA, Government Relations Director
- Natalie Littlefield/Tracy Monks, AHA, Community Health Directors

Q and A/Group Interaction

Ninety-two persons attended. The agenda, attendees, slides, Dr. Wright' transcripts and evaluations follow.



# Kentucky Public Health

Prevent. Promote. Protect.

## AGENDA

**Meeting Name:** Kentucky Heart Disease and Stroke Prevention Task Force

**Meeting Location:** Berry Hill Mansion, Frankfort, KY 40601

**Meeting Date & Time:** July 11, 2018 9:00 – 3:00 ET

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<b>8:30 – 9:00</b>	<b>Registration – Networking</b>	
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<b>9:00 – 9:30</b>	<b>Welcome</b> <ul style="list-style-type: none"><li>• Introductions</li><li>• Data Overview</li></ul>	<i>Bonita Bobo</i> <i>Karen Cinnamond</i>
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<b>9:30 – 9:40</b>	<b>Member Highlights</b> <ul style="list-style-type: none"><li>• Outstanding CARE Collaborative Partner Award – Norton Faith &amp; Health Ministries</li></ul>	<i>Bonita Bobo</i> <i>Lonna Boisseau</i>
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<b>9:40 – 10:45</b>	<b>Guest Presentation – Million Hearts® 2022</b> <ul style="list-style-type: none"><li>• Focus on Alignment</li><li>• Million Hearts® Accomplishments</li><li>• What must happen to prevent?</li><li>• 2018 Focus</li><li>• Q and A/Group Interaction</li></ul>	<i>Julie Harvill/April Wallace</i> <i>Jill Birnbaum</i> <i>Janet Wright, MD</i> <i>Million Hearts®</i> <i>Executive Director</i>
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<b>10:45 – 11:00</b>	<b>Break</b>	
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<b>11:00 – 12:00</b>	<b>Addressing Priorities, Work and Resources that align with Million Hearts®</b> <ul style="list-style-type: none"><li>• Kentucky Department for Public Health – KHDSP</li><li>• American Heart Association Health Strategies</li><li>• Q and A/Group Interaction</li></ul>	<i>Connie White, MD</i> <i>Senior Deputy</i> <i>Commissioner</i> <i>Amy Graham, Quality &amp;</i> <i>Systems Improvement</i> <i>Director</i> <i>Tonya Chang,</i> <i>Government Relations</i> <i>Director</i> <i>Natalie Littlefield/</i> <i>Tracy Monks, Community</i> <i>Health Directors</i>
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<b>12:00 – 12:45</b>	<b>Lunch – Networking</b>	
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<b>12:45 – 1:00</b>	<b>Kentucky Board of Emergency Medical Services</b> <ul style="list-style-type: none"><li>• Annual Report</li></ul>	<i>Chuck O'Neil,</i> <i>Deputy Executive</i> <i>Director</i>
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**1:00 – 2:30**

**Committee Breakout Sessions**

- SEQIP
- KASH
- STEMI
- Advocacy

*Kari Moore  
Holly Canfield  
Lesli McDonogh  
Tonya Chang*

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**2:30 – 2:45**

**Committee Reports**

*Kari Moore  
Holly Canfield  
Lesli McDonogh  
Tonya Chang*

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**2:45 – 3:00**

**Wrap Up**

- Evaluation and Feedback Process
- Communications
- KHDSF Task Force Survey
- Next Meeting September 19, 2018

*April Wallace  
David Davis  
Allie Merritt  
Bonita Bobo*

**Adjourn**

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### Advancing Million Hearts®

**Julie Harvill, MPA, MPH**  
Operations Manager

July 11, 2018




### Million Hearts® Collaboration

**April Wallace, MHA**  
Program Initiatives Manager

July 11, 2018




### Members - Million Hearts® Collaboration



### Advancing Million Hearts: AHA and Heart Disease and Stroke Prevention Partners working Together





### About AHA and CDC, DHDSP

- The AHA and the National Forum for Heart Disease and Stroke Prevention are co-chairs of the Million Hearts® Collaboration to Prevent Heart Disease and Stroke (MHC).
- The MHC is comprised of 14 member organizations




### Million Hearts® Partners calls

**Million Hearts® Partner Calls**

**Heart Million Hearts® Partner Call - July 31, 2018**  
Community Clinical Changes

- Tuesday, April 17, 2018 - Priority Population
- Tuesday, January 20, 2018 - Priority Population
- Tuesday, October 31, 2017 - Physical Activity

**Wednesday, August 30, 2017 - Community Clinical Linkages: Resources and a Early Year Roadmap**

**Tuesday, July 18, 2017 - Cardiac Rehabilitation**

**Tuesday, April 18, 2017 - Million Hearts® 2022**

**Program and the 100k Forward**  
Tuesday, February 15, 2017

**100k Forward Update**




### Advancing Million Hearts: AHA and Heart Disease and Stroke Prevention Partners working Together

**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.

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

- 1) Identify Million Hearts focused activities for 2018
- 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

**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®.




### About AHA and CDC, DHDSP

The MHC collaborates with the CDC's DHDSP to spread and promote evidence-based strategies and resources that prevent and control heart disease, stroke, and related risk factors.

The MHC works to strengthen, and improve, collaboration at the national, state and local level by:

- Sustaining strategic partnerships that make the greatest impact on CVD-related outcomes (14 members).
- Improving effective dissemination and promotion of key CVD prevention strategies, messages, and products to a broader stakeholder network.
- Providing leadership by committing to take action to advance Million Hearts 2022.




### Monthly Million Hearts® Messaging



The American Heart Association and the National Forum engage with our collaborators via a monthly messaging campaign to improve effective dissemination and promotion of key cardiovascular disease (CVD) prevention messages, evidence-based practices and resources that prevent and control heart disease, stroke and related risk factors, all of which work to help build national, state and local strategies to support CVD prevention and management.

**July 2018 - Million Hearts® Messaging: Air Quality**  
Summertime is here, making it the perfect time to get outside and exercised! But before you go, anyone with a history of heart disease should make sure to check the air quality in their area before heading outside. Studies show that air pollution is especially dangerous for those who have already had a heart attack or stroke.





### Million Hearts® in Action Stories

Million Hearts® success stories are summaries of achievements, outcomes, and/or lessons learned from projects focused on heart disease and stroke prevention.

- Heart Healthy Living (1)
- Hypertension (14)
- Medication Adherence (1)
- Partnerships/Collaborations (3)
- Personal Vignette (4)
- Smoking Cessation (4)
- Sodium Reduction (3)
- Stroke (1)
- WISEWOMAN (1)

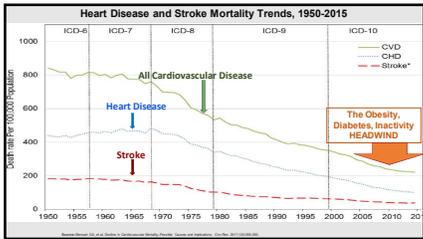



### Kentucky + Million Hearts 2022

*What One (Awesome) State Can Achieve*

Kentucky Heart Disease and Stroke Prevention Task Force  
Frankfort, Kentucky  
July 11, 2018

Janet Wright MD FACD  
Executive Director, MHSN Hearts

### Million Hearts® Collaboration Contact Information

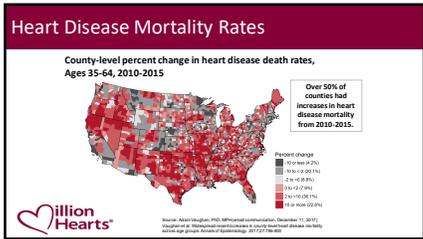
- Jill Birnbaum, VP, Global Advocacy & Strategic Opportunities, [Jill.Birnbaum@heart.org](mailto:Jill.Birnbaum@heart.org)
- April Wallace, Program Initiatives Manager, [April.Wallace@heart.org](mailto:April.Wallace@heart.org)
- Julie Harvill, Operations Manager, [Julie.Harvill@heart.org](mailto:Julie.Harvill@heart.org)
- Carma Potter, Project Coordinator, [Carma.Potter@heart.org](mailto:Carma.Potter@heart.org)

[www.heart.org/millionhearts](http://www.heart.org/millionhearts)




### Today's Objectives

- Million Hearts 2022 overview
- Lightning Round: Burning Questions and Feedback
  - What strikes you about this framework?
  - How could you use it to accelerate progress in Kentucky's cardiovascular and cerebrovascular health and care?
  - What "pieces" of Million Hearts 2022 would you like to hear about in more detail?
- The Gauntlet

### Facilitated Discussion with Dr. Janet Wright

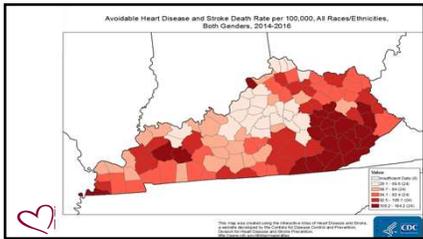
Jill Birnbaum, JD  
Co-chair, Million Hearts Collaboration  
VP, Global Advocacy & Strategic Opportunities

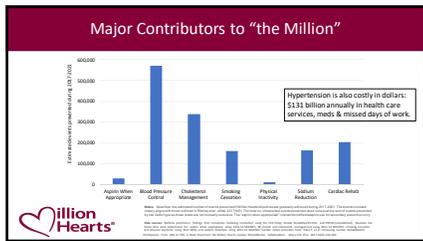
July 11, 2018




### Million Hearts® 2012—2016

- Improved BP control and Cholesterol management
- Issuance of trans-fat and sodium policies
- Target will likely be hit for tobacco prevalence
- By 2014, nearly **115,000 CV events** were prevented
- We estimate that **up to 500K events** will have been prevented when final data are available in 2019
- Million Hearts = 120 partners, 20 federal agencies, all 50 states, and the District of Columbia

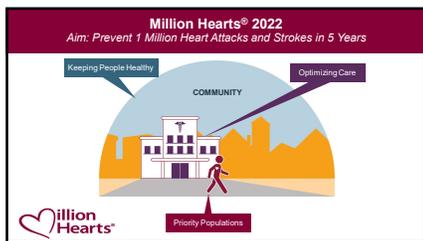


### Keeping People Healthy

Goals	Effective Public Health Strategies
<b>Reduce Sodium Intake</b> Target: 20%	<ul style="list-style-type: none"> <li>Enhance consumers' options for lower sodium foods</li> <li>Institute healthy food procurement and nutrition policies</li> </ul>
<b>Decrease Tobacco Use</b> Target: 20%	<ul style="list-style-type: none"> <li>Enact smoke-free space policies that include e-cigarettes</li> <li>Use pricing approaches</li> <li>Conduct mass media campaigns</li> </ul>
<b>Increase Physical Activity</b> Target: 25% (Prevention of inactivity)	<ul style="list-style-type: none"> <li>Create or enhance access to places for physical activity</li> <li>Design communities and streets that support physical activity</li> <li>Develop and promote peer support programs</li> </ul>

### Questions and Input

- What strikes you about this framework?
- How could you use this framework to accelerate progress in Kentucky cardiovascular and cerebrovascular health and care?
- What "pieces" of Million Hearts 2022 would you like hear about in more detail?



### Optimizing Care

Goals	Effective Health Care Strategies
<b>Improve ABCS*</b> Target: 80%	<ul style="list-style-type: none"> <li><b>Teams</b>—including pharmacists, nurses, community health workers, and cardiac rehab professionals</li> <li><b>Technology</b>—decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care</li> </ul>
<b>Increase Use of Cardiac Rehab</b> Target: 75%	<ul style="list-style-type: none"> <li><b>Processes</b>—treatment protocols, daily huddles, ABCS scorecards, proactive outreach, finding those with undiagnosed high BP or cholesterol, tobacco use, particulate matter exposure</li> <li><b>Patient and Family Support</b>—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</li> </ul>
<b>Engage Patients in Heart-healthy Behaviors</b> Target: 100%	

\*Apply use when appropriate. BP control, Cholesterol management, Smoking cessation

- ### New in Million Hearts 2022
- Physical activity
  - Cardiac Rehab
  - Engaging Patients in Heart-healthy Behaviors
    - Self-measured Blood Pressure Monitoring
  - "Priority Populations"
  - Particulate pollution

### Million Hearts® 2022 Objectives and Goals

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

Black/African Americans with Hypertension
35- to 64-year-olds due to rising event rates
People who have had a heart attack or stroke
People with mental and/or substance use disorders who smoke

\*Apply use when appropriate. Blood pressure control, Cholesterol management, Smoking cessation

### Improving Outcomes for Priority Populations

Priority Population	Objectives	Strategies
Black/African Americans	Improving hypertension control	<ul style="list-style-type: none"> <li>Deliver guideline-congruent treatment</li> <li>Problem-solve in medication adherence</li> <li>Advance practice of out-of-readings</li> <li>Increase access to and participation in community-based activity programs</li> </ul>
35-64 year olds	Improving BP control & statin use Decreasing physical inactivity	<ul style="list-style-type: none"> <li>Implement treatment protocols</li> <li>Increase access to and participation in community-based activity programs</li> </ul>
People who have had a heart attack or stroke	Increasing cardiac rehab referral and participation Avoiding exposure to particulates	<ul style="list-style-type: none"> <li>Use opt-out referral and CR liaison visits at discharge; ensure timely enrollment</li> <li>Increase use of Air Quality Index</li> </ul>
People with mental and/or substance abuse disorders who smoke	Reducing tobacco use	<ul style="list-style-type: none"> <li>Integrate tobacco cessation into behavioral health treatment</li> <li>Institute tobacco-free policy at treatment facilities</li> <li>Tailored quitline protocols</li> </ul>

### Cardiac Rehab Saves Lives and Improves Health

Road-tested Strategies to Boost Participation

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

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

Philip A. Ades, MD, Steven J. Kellerman, PhD, James S. Wang, MD, Loretta F. Ripstein, PhD, Ryan Liu, PhD, TDS Kimberly Pauley, Ashli Coronel S. Stewart, PhD, and Pamela J. Thomas, PhD, PhD

**Million Hearts** **CARDIAC REHABILITATION**  
 SAVING LIVES • RESTORING HEALTH • PREVENTING DISEASE

**BENEFITS OF CARDIAC REHABILITATION**

**Benefits to People**

- Those who attend 36 sessions have a **47%** lower risk of death and **31%** lower risk of heart attack than those who attend only one session.

**36 One Hour Sessions**

**Benefits to Health Systems**

- Costs per year of life saved range from **\$4,908 to \$9,200** per person.
- Cardiac rehab participation also reduces hospital readmissions.

**Cardiac Rehabilitation: What is the Impact?**

- Reduces:**
  - Death from **all** causes by 13-24%<sup>7</sup>
  - Death from **cardiac** causes by 26-31%<sup>7</sup>
  - Hospitalizations by 31%<sup>7</sup>
- Improves:**
  - Medication adherence
  - Functional status, mood, and Quality of Life scores<sup>11</sup>
- More is Better**
  - 36 vs fewer sessions reduces risk of heart attack and death<sup>12</sup>
  - 25 sessions is generally considered a healthy "dose"<sup>13</sup>

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**CR Referral: What are the System-Level Barriers?**

**Referral barriers include**

- Lack of awareness of the value of CR
- No clear, consistent signal to patients and families
- CR program is not integrated into CV services
- Eligible patients are not systematically identified
- No automated electronic referral process
  - "Opt-in vs Opt-out" hospital discharge orders<sup>17</sup>

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**Cardiac Rehabilitation: What is it?**

**Comprehensive, team-delivered out-patient programs that**

- Limit the effects of cardiac illness
- Reduce the risk for sudden death or re-infarction
- Control cardiac symptoms
- Stabilize or reverse the atherosclerotic process
- Enhance psychosocial and vocational status

Typically administered in 36 sessions over ~12 weeks

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**Cardiac Rehabilitation: Is Referral the Problem?**

- Referral to CR varies by qualifying condition**
  - ~80% for patients with a heart attack<sup>14</sup>
  - ~60% for patients who undergo angioplasty<sup>15</sup>
  - ~10% for patients with heart failure<sup>16</sup>

The strength of the physician's endorsement is the greatest predictor of CR participation.<sup>17</sup>

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**CR Participation: Who does—and does not—participate?**

- Participation rates vary by diagnosis**
  - Higher for heart attack (~14%) and bypass surgery (31%)<sup>19</sup>
  - Lower for patients with heart failure (<3%)<sup>20</sup>
- Lower participation rates among**
  - People of color
  - Women
  - Elderly
  - People with co-morbidities or low socio-economic status<sup>16, 21</sup>
- Significant geographic variation<sup>22, 23</sup>**

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**Cardiac Rehabilitation: Who Benefits?**

**Strong evidence of benefit—and good insurance coverage—for individuals who have**

- Had a heart attack.<sup>1</sup>
- Stable angina.<sup>2</sup>
- Received a stent or angioplasty.<sup>3</sup>
- Heart failure with ejection fraction ≤ 35%.<sup>4</sup>
- Undergone bypass, valve, or a heart, lung, or heart-lung transplant surgery.<sup>5-8</sup>

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**CR Referral After Cardiac Stent: Striking Variation across Hospitals**

- 60% overall referral rate
- The **HOSPITAL** was the most important factor for predicting referral rate
- Ranges from 0 to 100%

FIGURE 3. Interhospital Variation in Cardiac Rehabilitation Referral Rates. Distribution of cardiac rehabilitation referral rates across hospital sites adjusted (darkred) and unadjusted (blue) for insurance status. NCHS = National Cardiovascular Data Registry. Aragon et al. J Am Coll Cardiol 2015;May 19: 65 (19): 2079

**Million Hearts**

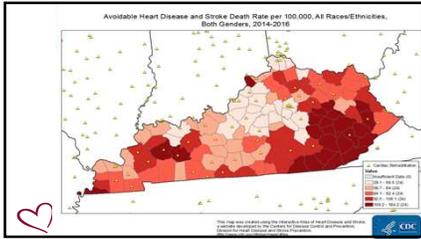
**CR Participation: What Barriers do Patients Face?**

**Participation barriers include**

- Logistics
  - Transportation/parking
  - Convenient hours
  - Proximity of programs
  - Cost-sharing
  - Competing responsibilities
  - Cultural and language issues<sup>18</sup>

Only 20% to 30% of eligible people in the U.S. are participating in cardiac rehabilitation.<sup>18</sup>

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### Self-Measured BP Monitoring

- Strong evidence for SMBP + clinical support for achieving control
  - 1:1 counseling
  - Group classes
  - Web-based or telephonic support
- Good evidence for SMBP for confirming diagnosis

**The BP Power Cycle**

### Progress to the Ideal System?

- ✓ Compelling case for accuracy and OOO readings
- Billing codes or value-based contracting
- Performance measure(s) that consider OOO readings
- EZ, smart connection between patients and clinicians
- Exemplars and implementation guidance
- Activation of people with HTN to "own" their BPs

### Million Hearts CR Collaborative 2018-2021 Action Plan Objectives

- Increase awareness of the value of CR among health systems, clinicians, patients and families, employers, payers
- Increase use of best practices for referral, enrollment, and participation; address knowledge gaps.
- Build equity in CR referral, participation, and program staffing
- Increase sustainability of CR programs through innovations in program design, delivery, and payment
- Measure, monitor, report progress to the 70% aim

### 2017 Guidelines SMBP Recommendations

COB	LOE	Recommendation
I	A*	1. Out-of-office BP measurements are recommended to confirm the diagnosis of hypertension (Table 3) and for titration of BP-lowering medication, in conjunction with telehealth counseling or clinical interventions (1-4).
OR replicate telehealth services.		
COB	LOE	Recommendation
I	A	1. Follow-up and monitoring after initiation of drug therapy for hypertension control should include systematic strategies to help improve BP, including use of HBPM, team-based care, and telehealth strategies (1-4).

### National SMBP Steering Committee and Forum

- Vision: SMBP will be accessible to everyone for diagnosis and management of hypertension
- National leaders—researchers, clinicians, public health experts, community organizations—are developing the roadmap
- Those committed to advancing SMBP are welcome to join the quarterly Million Hearts SMBP Forum

### Engaging Patients in Heart-healthy Behaviors

- Self-Measured BP Monitoring
- Participation in
  - Diabetes Prevention Program
  - Chronic Disease Self-Management Program
  - Cardiac Rehab
- In consideration
  - Shared Decision-making around statin use
  - Keeping a Physical Activity log and sharing with clinical team

### SMBP Implementation Challenges

- Lack of a standard definition, protocol
- Distrust of readings
- Health IT limitations
- Patient-generated data are not used in quality metrics
- Coverage for or access to BP monitors
- Reimbursement for clinician time to
  - Train patients and families
  - Validate monitors
  - Interpret home readings and provide timely advice

### Million Hearts® Accelerating SMBP in Kentucky

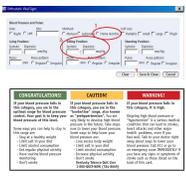
Health Center Teams	SMBP Measures	Total Patients (Jul '17 – May '18)
<ul style="list-style-type: none"> <li>• Aflac/KentuckyCare</li> <li>• Shawnee Christian Health Center</li> <li>• White House Clinics</li> </ul>	Recommendation of SMBP	716
	Use of SMBP among HTN Patients	477
<b>Local YMCAs</b> <ul style="list-style-type: none"> <li>• YMCA of Greater Louisville</li> <li>• Central Kentucky YMCA</li> </ul>	Referral to Community Program (e.g. Y BP/SM)	39
<b>Local Public Health</b> <ul style="list-style-type: none"> <li>• Purchase District Health Department</li> </ul>		
<b>State and Regional Organizations</b> <ul style="list-style-type: none"> <li>• Kentucky Health Center Network</li> <li>• Kentucky State Alliance of YMCAs</li> <li>• Kentucky Dept. for Public Health</li> </ul>		

"We were really excited with the early success of our program. We saw a 5% increase in the number of patients whose blood pressure was controlled over a relatively short implementation period."

Stephanie Moore, MPA, CMPE,  
CEO, White House Clinics

### Kentucky SMBP Best Practices

- Develop a written protocol with detailed EHR screen shots
- Train ALL staff on executing the protocol → ensure a "warm handoff"
- Train and use CHWs to:
  - Provide education on risk factors and lifestyle changes
  - Document BP measurements and calculate averages
- Use CARE Collaborative BP log and educational materials



### You and Your Family

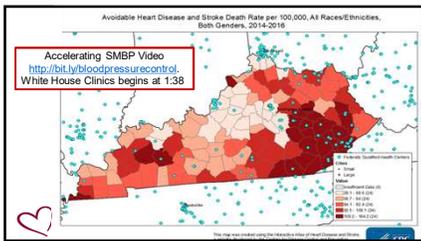
- Aim for at least 150 min/week of physical activity
- Read the labels for sodium and choose wisely
- Know and manage your ABCS
- Check the AQI and mitigate your exposure to PM 2.5
- Attend CR and encourage family and friends to do so



### Health System Leader

*Set Expectations and Equip Your Teams to*

- Achieve 80% performance on the ABCS among ambulatory primary care and relevant specialty practices
- Achieve 90% referral to CR programs of those eligible
- Achieve 70% initiation rate among those eligible for CR
- Recognize/reward high performance on ABCS and CR

### Healthcare Professional

- Prioritize and excel in the ABCS and CR referral

- Teams**—including pharmacists, nurses, community health workers, and cardiac rehab professionals
- Technology**—decision support, patient portals, e- and detail referrals, registries, and algorithms to fill 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 BP monitoring, problem-solving in medication adherence, counseling on nutrition, physical activity, tobacco use, role of participant matter, referral to community based physical activity programs and cardiac rehab



### Million Hearts Employer

- Adopt policies and practices to ensure clean air for employees, visitors, and staff
- Design benefits to enhance employee health:
  - No cost-share for BP, statin, tobacco cessation meds, cardiac rehab
  - Free BP monitors
- Provide on-site BP monitoring with clinical support
- Sponsor walking and other physical activity programs
- Procure and label food consistent with national food service guidelines



### SO..... What Can Kentuckians Do?

- Individual and Family Member
- Healthcare Professional
- Community Member and Public Health Expert
- Health System Leader
- Employer



### Community Members and Public Health Experts

- Enact pricing strategies and smoke-free space policies, inclusive of e-cigarettes
- Serve or request healthy food at all meetings, in all facilities
- Contribute to healthy design of your community and to accessible, affordable, and safe places to be active
- Improve awareness of the local air quality index
- Build linkages between health systems and community resources



### Requests and Up-comings

- Join the CR Collaborative and/or the SMBP Forum
- Visit [millionhearts.hhs.gov](http://millionhearts.hhs.gov)
  - Hypertension Control Change Package
  - SMBP and Hiding in Plain Sight videos and guides
  - Million Hearts microsite for *evergreen* clinical resources
- Coming soon**
  - Cardiac Rehab Change Package on website this September!
  - Vital Signs in September with Kentucky's "share" of events
  - 2018 Hypertension Champions announced this fall



### Thank you

- More on Million Hearts 2022 at [millionhearts.hhs.gov](http://millionhearts.hhs.gov)
- To join
  - CR Collaborative, contact Haley Stolp at [hstolp@cdc.gov](mailto:hstolp@cdc.gov)
  - SMBP Forum, email [MillionHeartsSMBP@nacho.org](mailto:MillionHeartsSMBP@nacho.org)
- Reach me at [janet.wright@cms.hhs.gov](mailto:janet.wright@cms.hhs.gov)



### New Resources

- Million Hearts® 2022 web content
  - [Pericete Pollution](#)
  - [Physical Activity](#)
  - [Tobacco Use](#)
  - [Partner Opportunities](#)
  - [Cardiac Rehabilitation](#)
- EPA's citizen science mobile app: [Smoke Sense](#)





### Million Hearts Community Resources and Tools

- Action Guides
  - [Self-Measured Blood Pressure Monitoring: Action Steps for Public Health](#)
  - [Medication Adherence: Action Steps for Public Health Practitioners](#)
  - [Medication Adherence: Action Steps for Health Benefit Managers](#)
  - [Cardiovascular Health: Action Steps for Employers](#)
- CDC State Heart Disease and Stroke Prevention Programs
  - [State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health \(1305\)](#)
  - [Covered National Acute Stroke Program](#)
- WISEWOMAN
  - [Sodium Reduction in Communities](#)
  - [Building GIS Capacity for Chronic Disease Surveillance](#)
- Million Hearts Cardiac Rehab Collaborative
- Healthy is Strong
- 100 Congregations for Million Hearts



### Resources and Additional Data



### Resources for Finding those with Undiagnosed Hypertension

- [Maine Center for Disease Control and Prevention HIPS video](#) – <https://vimeo.com/136616637>
- [National Association of Community Health Centers – Consolidated Change Package](#) - leverages HIT, QI, and care teams to identify hypertensive patients hiding in plain sight
- [Hypertension Prevalence Estimator](#) - For practices/systems to use to estimate their expected hypertension prevalence
- [Whiteboard animation](#) – a creative depiction of the "hiding in plain sight" phenomenon and what clinical teams can do
- <https://millionhearts.hhs.gov/tools-protocols/hiding-in-plain-sight/index.html>



### Million Hearts Consumer Resources and Tools

- [Heart Age Predictor](#)
- [My Life Check](#) Ⓞ
- [High Blood Pressure: How to Make Control Your Goal](#)
- [Visit Checklist](#)
- [Supporting Your Loved One with High Blood Pressure](#)
- [Blood Pressure Wallet Card](#)
- [Smoke Free \(SF\)](#)
- [Million Hearts Videos \(on YouTube\)](#)
- [Million Hearts E-Cards & Shareables](#)
- [Mind Your Risks](#)
- [Tips from Former Smokers](#)




### Million Hearts® Microsite for Clinicians

- 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




### Million Hearts Clinical Resources and Tools

- Action Guides
  - [Hypertension Control: Change Package for Clinicians](#)
  - [Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians](#)
  - [Identifying and Treating Patients Who Use Tobacco: Action Steps for Clinicians](#)
  - [Team Protocols for treating Hypertension, Tobacco use, Cholesterol](#)
- [Undiagnosed Hypertension: Finding Patients "Hiding in Plain Sight" change package](#)
- [Prevalence Estimator Tool](#)
- [Making the Most of Health IT](#)
  - [Million Hearts® EHR Optimization Guides-how to find and use data on the ABCS](#)
- [Clinical Quality Measures](#)
  - [Million Hearts® ABCS](#)
  - [Million Hearts® Dashboard](#) - quality reporting on the ABCS measures by state
- [Other Tools](#)
  - [ACVD Risk Estimator](#)
  - [Hypertension Control Champion Success Stories](#)



### Self-Measured BP Resources

Guidance for clinicians on:

- Training patients to use monitors
- Checking home machines for accuracy
- Suggested protocol for home monitoring
- Cuff loaner program

<https://millionhearts.hhs.gov/tools-protocols/smbp.html>




### Tips for Communities to Improve Physical Activity

- Create or enhance access to places for physical activity
- Design communities and streets that support physical activity
- Develop and promote peer support groups

WALK WITH EASE  
A program for Senior Living

ARTHRITIS  
FIGHT IT WITH EASE

Million Hearts

### Populations At-Risk Are Known

**Susceptible populations include –**

- Populations with pre-existing respiratory disease
- Populations with pre-existing cardiovascular disease
- Adults 65 years of age and older
- Populations with lower socio-economic status
- Children & the developing fetus

**Populations suspected to be at greater risk –**

- Populations with chronic inflammatory diseases (e.g., diabetes, obesity)
- Populations with specific genetic polymorphisms (e.g., GSTM1) mediate physiologic response to air pollution

Million Hearts

### What is JUUL?

- Electronic vaporizer that uses nicotine salts
- Promoted as a "satisfying alternative to cigarettes"
- "By accommodating cigarette-like nicotine levels, JUUL provides satisfaction to meet the standards of smokers looking to switch from smoking cigarettes."
- Available in tobacco, fruit, mint and other flavors
- Every JUUL flavored pod contains nicotine

Million Hearts

<https://www.juul.com/>

### Million Clicks for Million Hearts®

- Allentown, PA Health Bureau program
- 10 click-in stations on walking paths around the city
- Participants tap a keytab to track their walks
- PRIZES!

Million Hearts

### Really Good News: Barbers + Pharmacists Teaming Up with Clinicians

**Results**

Intervention @ 6 months: 152.8 ± 27 = 132.8mm Hg  
63.6% reached <130/80

Control @ 6 months: 154.6 ± 9 = 145.4mm Hg  
11.7% reached <130/80

**LESSONS**

1. Community care
2. Pharmacist prescribed dual therapy by protocol
3. Frequent contact
4. Aimed for lower target

Million Hearts

### JUUL – Nicotine Delivery

Legend: combination cigarette (yellow), PAX Labs platform - commercial version (purple)

Million Hearts

### Particle Pollution

- PM<sub>2.5</sub> refers to particulate matter of 2.5 micrometers or less in diameter
- Exposure is linked to an increase in risk of heart attacks, strokes, and rhythm disorders
- Particle pollution info on Million Hearts website

Million Hearts

### What is THIS?

Million Hearts

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

**Tanya Chang**  
Senior Director of Government Relations for Kentucky and West Virginia

**Amy Graham, RN, BS, CEN**  
Director, Quality and Systems Improvement for Kentucky and Southwest Ohio

**Natalie Littlefield, MPH**  
Community Health Director for Lexington and Eastern Kentucky

**Tracy Manks**  
Community Health Director for Louisville and Western Kentucky

Million Hearts

**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%.

**AHA and Million Hearts®  
Spotlight on Kentucky**

Health Strategies

- Advocacy
- Quality and Systems Improvement
- Community Health
- Communications

**AHA and Million Hearts®  
Spotlight on Kentucky**

- **Active Living** - physical education in elementary and middle schools, public reporting on physical education, making physical education an indicator under ESSA, complete streets, Safe Routes to Schools
- **Access to Care** - Medicaid expansion, preventative benefits, tobacco cessation
- **Securing appropriations**



**AHA and Million Hearts®  
Spotlight on Kentucky**

**Advocacy**  
We work at the federal, state and local level to advocate for evidenced-based health policies that address cardiovascular and brain health.

Policy priorities are determined each year by working closely with our state advocacy advisory committee.

**AHA and Million Hearts®  
Spotlight on Kentucky**

**Advocacy Successes:**

- Pulse oximetry screening for newborns
- Stroke facility designation and registry
- CPR for all KY high school students
- Comprehensive coverage of smoking cessation services for Medicaid and private insurance
- Healthy vending policy in Louisville
- Telephone CPR training and implementation for 911 telecommunicators

**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.

**AHA and Million Hearts®  
Spotlight on Kentucky**

**Advocacy Priorities**

- **Tobacco Free** - comprehensive smoke-free policies, program funding, cessation, raising the tobacco excise tax and removing the state restriction on local tobacco retail policies
- **Quality Systems of Care** - Stroke and STEMi facility designations, registries and T-CPR
- **Healthy Eating** - healthy restaurant kids' meals, healthy eating in public places, healthy food financing initiatives, early care and education centers

**AHA and Million Hearts®  
Spotlight on Kentucky**

**How You Can Help/Ways to Engage:**

- Join our You're the Cure Network: <http://www.yourethecure.org>
- Follow us on social media
- Join our HDSTF Advocacy Subcommittee
- Join the AHA Kentucky Advocacy Advisory Committee
- Attend our KY Advocacy Day at the Capitol February 2019

### AHA and Million Hearts® Spotlight on Kentucky

**Quality & Systems Improvement**  
*Get With The Guidelines & Mission: Lifeline*

When medical professionals apply the most up-to-date evidence-based treatment guidelines, **patient outcomes improve.**

### 2018 Mission: Lifeline EMS Quality Achievement Awards

<p><b>2018 Mission: Lifeline</b></p> <ul style="list-style-type: none"> <li>Boyle County EMS</li> <li>Independence Fire District</li> <li>Jessamine County EMS</li> <li>Louisville Metro EMS</li> <li>Madison County EMS*</li> <li>Mercy Regional EMS</li> </ul>	<p><b>2018 Mission: Lifeline</b></p> <ul style="list-style-type: none"> <li>Central Campbell Fire District</li> </ul>	<p><b>2018 Mission: Lifeline</b></p> <ul style="list-style-type: none"> <li>Medical Center EMS*</li> <li>Shelby County EMS</li> <li>Woodford County EMS</li> </ul>	<p><b>2018 Mission: Lifeline</b></p> <ul style="list-style-type: none"> <li>Air Methods Kentucky</li> <li>Exitt County EMS</li> <li>Georgetown/Scott County EMS</li> <li>Powell County EMS</li> </ul>
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### 2018 Get With The Guideline Quality Achievement Awards

- Get With The Guidelines CAD
  - Baptist Health Floyd Mission: Lifeline Bronze Receiving award
  - Jewish Hospital Mission: Lifeline Gold Plus Receiving award
  - Norton Audubon Hospital Mission: Lifeline Gold Receiving award
  - Norton Brownsboro Hospital Mission: Lifeline Gold Receiving award
  - Norton Hospital Mission: Lifeline Silver Plus Receiving award

### AHA and Million Hearts® Spotlight on Kentucky

**Quality & Systems Improvement Priorities**  
*Get With The Guidelines: AFIB, CAD, HF, Resus, Stroke*  
*Patient Management Tools (PMT)*

<ul style="list-style-type: none"> <li>Real-time data collection</li> <li>Point-of-care education materials</li> <li>Integrated decision support</li> <li>Arrival, discharge, and follow-up care</li> <li>Burns</li> <li>Professional education opportunities – workshops/webinars</li> <li>Education</li> </ul>	<ul style="list-style-type: none"> <li>AHA Quality Improvement Field Staff Support</li> <li>Recognition – national/local for hospital team achievement</li> <li>Center for Medicare and Medicaid (CMS) data submission*</li> <li>Performance feedback reporting for continuous QI</li> <li>Cost Effectiveness</li> </ul>
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### 2018 Get With The Guideline Quality Achievement Awards

- Get With The Guidelines Stroke
  - Baptist Health Lexington Gold Plus Target: Stroke Heart Full Size Plus award
  - Baptist Health Louisville Gold Plus award
  - Baptist Health Louisville Gold Plus Target: Stroke Heart Full Size Plus award
  - Franklin Regional Medical Center Silver award
  - Tyler-Greeneboro Regional Hospital Gold Plus Target: Stroke Heart Full award
  - Wash Hospital Gold Plus Target: Stroke Heart Full award
  - Wendell-Cheatham Gold Plus Target: Stroke Heart Full award
  - Wake-Cumberland Regional Hospital Gold Plus Target: Stroke Heart Full award
  - Western Atrium Hospital Gold Plus Target: Stroke Heart Full award
  - Western Atrium Children's Hospital Gold Plus Target: Stroke Heart Full award
  - Western Atrium Medical Center Gold Plus award
  - St. Elizabeth Edgewood Gold Plus award
  - St. Elizabeth Florence Gold Plus Target: Stroke Heart Full award
  - St. Elizabeth Thomas Gold Plus award
  - St. Mary and Bethel Hospital Gold Plus Target: Stroke Heart Full award
  - The Medical Center – Bowling Green Gold Plus Target: Stroke Heart Full award
  - UK Healthcare Gold Plus Target: Stroke Full Plus award
  - University of Louisville Hospital Gold Plus Target: Stroke Full Plus award

### Tools and Resources

**Online Tools**

- My Life Check
- Heart Attack Risk Calculator
- AHA's Smoking Cessation Tools and Resources

**Resources**

- Get With The Guidelines – [www.heart.org/quality](http://www.heart.org/quality)

### Quality and Systems Improvement “By The Numbers”

- # of Acute Care Hospitals located in the Great Rivers Affiliate = 437 (DHC 2015)
- # of hospitals participating in at least one Get With The Guidelines® module = 304 (69.5%)
- # of GWTG modules implemented at hospitals in GRA = 437
- # of GWTG Performance Achievement Awards earned by hospitals in 2018= 454
- # of EMS Agencies in GRA who received Excellence in Quality Improvement Awards = 152
- # of Disease Specific Hospitals in GRA= 266

(Includes Cardiovascular Centers of Excellence, Comprehensive Stroke Centers, Primary Stroke Centers, Acute Stroke Ready Hospitals, Advanced Heart Failure and Mission: Lifeline Heart Attack Centers)

### 2018 Get With The Guideline Quality Achievement Awards

- Get With The Guidelines Heart Failure
  - Baptist Health Lexington Gold Plus Target: Heart Failure award
  - St. Elizabeth Edgewood Gold Plus Target: Heart Failure award
  - St. Elizabeth Florence Gold Plus Target: Heart Failure award
  - St. Elizabeth Ft. Thomas Gold Plus Target: Heart Failure award
  - The Medical Center – Bowling Green Bronze Target: Heart Failure award
- Get With The Guidelines Resuscitation
  - Baptist Health Louisville Bronze award
  - UK HealthCare Gold award
- Get With The Guidelines A Fib
  - St. Elizabeth Edgewood Gold award
  - St. Elizabeth Ft. Thomas Gold award
  - St. Elizabeth Florence Gold award

### AHA and Million Hearts® Spotlight on Kentucky

**Community Health Role**

- First time position for Lexington office
- Focusing on a state-wide effort to improve cardiovascular disease and stroke death rates in Kentuckians

**Vision**  
Increase life expectancy throughout the state of Kentucky

**Goals**  
 - Increase food access  
 - Increase support for physical activity  
 - Improve blood pressure control

**Strategies**  
 - Leverage existing American Heart Association programs (Target BP, Mobile Kitchen, Change Control)  
 - Expand upon existing relationships with stakeholders and develop new partnerships needed

**HEALTH BEHAVIORS**

- Opportunities for Physical Activity
- Healthy Food Options
- Weight Management
- Smoke-Free Status

**7 HEALTH INDICATORS**

- Manage Blood Pressure
- Reduce Glucose Levels
- Control Cholesterol

### Contact Information

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### Community Health Strategies

- Existing AHA initiatives
  - Target BP
  - Check.Change.Control
  - Check.Change.Control Cholesterol
  - Mobile Kitchen Series
  - Simple Cooking with Heart

### Discussion

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

100 Million Hearts

Q & A

### HELP BREAK THE CYCLE and improve better social determinants of health

Social determinants of health have a tremendous impact on quality of life and well-being.

This process will help you consider which factors may influence the health and well-being of people in your local community.

### Contact Information

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*Janet Wright:*

Good morning, everyone in Kentucky. I am so grateful that, through enormous amounts of work on your part and the work of that fabulous AHA team that I'm able to join you at a distance. I'd much prefer to be there in person.

And I want to start with a note of gratitude. First, to the task force—you all have been at this for a long time. Clearly, by the numbers, both the numbers of people in the task force and the results that you're generating, you are doing awesome work. So, on behalf of the whole Million Hearts team, both in Atlanta at CDC and in Baltimore at CMS and other partners, federal and private—thank you for the devotion that you've put into this, the commitment, and as we said, the results that you are generating.

I also want to call out Julie Harvill and Mary Jo and Karma and April for all the work they've done in providing opportunities for Million Hearts to be at meetings around the country, and particularly for overcoming all the obstacles for me to be able to participate today. Bonita and Lonna, wonderful to get a visual of you yesterday, and again, thank you for your work.

This is going to be, I hope, an interactive episode for us today as much as we can make it, and Jill, I wanted to call you out. You are the mobile, global heart disease and stroke prevention action agent. I was thinking this morning you go from Kentucky to Kazakhstan over a weekend—and thank you for trying to be the link between me today.

So, I do want to call out some of the things I've learned about Kentucky. One is this enormously valuable CARE Collaborative and the work that you've done. I will call it out on the slide if we go in that direction later, but others that I've discovered, digging into Kentucky, is this Kentuckian Health Collaborative, and I imagine that many of you in the room have been part of the effort of the collaborative working with the Kentucky Department for Medicaid Services in developing a core measure set. I didn't call out that massive accomplishment on a slide, but I will note that the Million Hearts tobacco measure, the blood pressure measure, the statin measure, and the BMI measure are all included in that core set. So, congratulations if you were a part of the effort. If you don't know about the effort, please check in with them and check out that core set.

Okay. Today's objectives. I know that many of you are familiar with Million Hearts, but I thought I would go through the framework, really, with the purpose of helping free up opportunities

that might be a good fit for Kentucky, things that you're already working on but that we might highlight a resource or two that you didn't know about or perhaps partners that you could more deeply engage, or maybe new areas that sound exciting to you and again, would be a good fit in Kentucky.

In about 10 slides from now, we're going to stop and ask you these questions. I'd love feedback on this framework. What jumps out at you? Does something about it scare you? Does it strike you as completely unrealistic, impossible—we sort of major in the impossible in Million Hearts—or very exciting? And if it sounds a little off to you or if it's not a good fit for Kentucky, I would really love to hear more about that.

Second question is, how could you use any parts or pieces of this framework to accelerate the progress in your work in Kentucky? And then finally—really relevant to today's presentation—what parts of Million Hearts 2022 would you like to hear more about? I prepared slides on cardiac rehab and on self-measured blood pressure monitoring, but if neither of those really appeals to you, we can dig into any other part, new or old, in Million Hearts, and that's where Jill has her running shoes on and is going to help us steer the rest of the presentation in the direction that would be most meaningful to you.

I did throw in some slides at the end about individual and sector types of actions. I know you were meeting in breakout groups this afternoon, and we probably won't go over those slides, but I provide them in case it helps stimulate additional thinking.

So, what are the results of the first five years? I know you all were deeply involved in that. And the bottom line is, we may, by the time the final numbers are available, we think the tobacco target, based on work you've done and others around the country, I think we will hit the tobacco target. But the improvement in blood pressure control and cholesterol were slower than we hoped, about 1 percent per year for blood pressure, 2 percent for cholesterol or statin use.

The trans-fat and sodium policies got out the door from federal agencies, but of course, the implementation timeline on those is lengthy, and the impact is still down the road. But the bottom line is that, when final numbers are available in 2019, we predict that somewhere around 500,000 events will have been prevented during that first five year period. Certainly not insignificant, but short of a million. And I want to be clear that any time I talk about

results, I'm not talking about the Million Hearts team or even the fabulous Million Hearts collaborative by itself; but all of the partners, all of the work that's going on, and all of the work, frankly, that's going on in the country unrelated to Million Hearts, where we try to shower credit and highlight high performers.

So, what is working against us? This is what's working against us. For decades, we've seen a nice decline in cardiovascular disease mortality, both heart disease and stroke. But over the last six or seven years, maybe eight, we've seen a flattening, probably due to the decades of obesity, diabetes, and physical inactivity, hitting, finally, on the event rates. This is what we're working against, and we think this played a bit of a factor in the problems of achieving the million, but more importantly, it's a big problem for our entire country, and that's why the work that you're doing and your colleagues who are focused, and ours, directly on obesity and diabetes, will help all of us bend this trend back down.

This is a slide that keeps me up at night. I suspect that you're aware of it, but it was really big news for us that, over the last five years or so, mortality rates are—not just event rates, but mortality rates are actually on the rise in the younger age group. When we look at our data, we saw a decline in the 65 and older, but a rise in death rates and event rates in 35 to 64-year-olds. The other thing that this map shows is that it's not only a Stroke Belt problem, anymore. It is Maine to California where heart rate deaths are rising.

Again, this is probably a factor or a product of diabetes, obesity, physical inactivity, and there may be the issues of economic stresses that are playing in here, even though those are very hard to measure. All the more reason to get a collected effort going.

Now, I know you all are very familiar with this map or maps like this. This happens to be avoidable heart disease and death rates, so deaths from cardiovascular disease occurring at an age younger than 70, and you see a real cluster in that Southeast portion of Kentucky, with some higher areas in other places, as well. I'll just leave you with that image. These are data from 2014 and '16. We'll return to this map in a little bit.

So, what do we do about this? We did modeling to look, take a fresh look, at what could help prevent a million events over a five-year period. We worked with three different external predictive modelers and, actually, it reconfirmed what we focused on in the first five years. This chart takes a little bit of explaining. What you see, of course, are the major factors that we think contribute to

preventing heart attacks, strokes, and other preventable causes of heart disease. And what's reflected here are the number of events that could be prevented if the targets were achieved over the five-year period of 2017 to 2021. Clearly, blood pressure control is the major contributor, with cholesterol management a close second.

What I'd like to point out on this chart is that the modeling was done with aspirin for secondary prevention. In this current phase of Million Hearts, we're focusing on aspirin for primary and secondary, so you really could increase the size of that bar for aspirin, a greater number of events prevented when you improve aspirin for primary prevention as well

A note on physical inactivity—clearly, improving physical activity is important for pretty much everything, but the number of events prevented over a five year period by reducing inactivity is on the small side, but this is not meant to underestimate the value of physical activity.

Sodium reduction has its impact through blood pressure control so you could think there's a little bit of overlap there in events prevented. And the important thing to know about cardiac rehab is that these are second events that are being prevented, not first events, but site a very significant number of events. Again, I'm happy to take questions about this later.

So, this is the pictograph of the structure of Million Hearts. Those of you who are familiar know that we used keeping people healthy to indicate the community or public health actions, optimizing care to indicate those actions that can be executed in a clinical setting. We've added a third leg, a tripod structure now, with a deep, abiding focus on high burden and high-risk population.

Now, I want to be clear—we're trying to prevent heart attacks and strokes for everyone, in everyone, but we're trying to call additional attention and focus additional action on subsets that suffer a particularly high burden. We'll go over that in a moment.

This next slide shows that same framework with a little more detail Keeping people healthy up in the upper left corner are those public health or really big levers. We're sticking with sodium and tobacco and adding a focus on physical activity. Over on the right side in the clinical care area, we're sticking with the ABCS, because there's room for improvement, adding a focus on cardiac rehab, and then CMS in particular, you're, we're co-led by CDC and CMS. CMS was particularly interested in actions and activities

that engage people sort of initiated in the clinical setting, but then carried on when that person is at home and in their community. The major experience for us so far is self-measured blood pressure monitoring; also, participation in the diabetes prevention program and cardiac rehab.

And then, down below, are the priority populations that we chose. First of all, we realize that we may not have chosen one that is particularly resonant with people in Kentucky or in certain areas of Kentucky, but we would encourage you to focus on a priority population based on the data that is most meaningful for you. The ones we've chosen are African-Americans and blacks with hypertension, because there's such a difference in control rates by race, 35 to 64-year-olds, as I mentioned, because of rising event and death rates, people who have already had a heart attack and stroke where there remain some gaps in care and in behavior change following those events, and then individuals who are struggling not only with a mental illness or substance use disorder, but also smoke. The current data show that tackling both of those challenges at once actually is more stressful for that person than staging them—again, more details available on that if you're interested.

So, I won't go through these slides in great detail, but I want you to know that the strategies that were selected here came from the literature, from subject matter experts, and also from places in the country that are doing this well. We've set 20 percent improvement targets for each of these. In the optimizing care area, we've set 80 percent targets for the ABCS. We've done this because we know it's achievable. We know there are high performers out there that are doing this. But most importantly, 80 percent is more likely to get more people free of heart disease and stroke.

Participation rates of 70 percent in cardiac rehab, which is quite a stretch, and then as I mentioned, we've not set a target yet for SMBP, because it is more of a developmental activity, but the strategies that are listed here are things we have gleaned, again, from those who are doing this well, who've been so generous with the lessons that they've learned, and you definitely have examples of that here in Kentucky.

This is just more detail on the priority populations. I won't walk through the slides, but we were trying to give you more details to flesh out what could sound like a concept.

And then we'll stop now, and I don't know if you've had a chance to write some answers to those questions or if Jill is able to get some feedback from you on these three, but particularly with that last one, your answers will help decide—will help us decide what direction we take for the remaining minutes this morning. Jill?

*Jill:* Great. Thanks, Janet. So, we're going to collect cards, right now.

*Janet Wright:* Great, and if you think it's right, Jill, I can advance to the next slide, which may help people pick a topic. And I hope you all laugh—I did put in bold where I've prepared slides, but again, I'm not tied to those, and I'm also happy to go into more detail about some of the carryovers from the first five years, if these newer activities don't hit high on your list.

*Jill:* Okay. So, we're going to just ask folks to stand if you've got ideas on where we want to head next. Let me ask this question—how many of you are interested in digging a little bit more into cardiac rehab? Okay, Janet, we've got about a half dozen hands.

Okay. How about self-measured blood pressure monitoring? A lot of hands went up for that, Janet.

*Janet Wright:* Alright!

*Jill:* Okay. Anything else? Those are the two big ones. Anything else here that is of interest to you? Tonya?

So, Janet, there's a request here to get into more detail into the mental health and substance abuse and tobacco use.

*Janet Wright:* Great.

*Jill:* Over here. Okay. More on how to engage the community in heart healthy behaviors.

*Janet Wright:* Great.

*Jill:* Other ideas that would be helpful going into your work together, later today? Okay, that's the sense of the room, Janet.

*Janet Wright:* Awesome! Thank you very much. Well, let's—maybe I'll go back and address the mental health and substance use. At the bottom of the slide, and on the right, are the strategies that we have, again, gleaned from experts, including our colleagues at SAMHSA and

other private sector organizations, that these are likely to have an impact.

And just, in a really broad brush, what the evidence now shows us is that the self-esteem and the mastery that comes from stopping smoking while you are dealing with another substance use problem or a serious mental disorder actually is sufficient or beneficial. It's almost fuel to help the person deal with their second problem.

Again, this goes counter to everything I've practiced, everything I personally would imagine, that I wouldn't have the psychic bandwidth to tackle two major things at once and I should stage those, and yet, that appears not to be the case.

So, SAMHSA in particular has wonderful handouts, both for individuals and for clinicians and counselors that help walk through the steps that would help someone who's battling what, basically, is a set of serious dual problems. I didn't put that resource in my list, but I'm happy to follow up and get that back to you all

You see a strategy here that deals with treatment centers—believe it or not, in many behavioral health treatment places, smoking is allowed. I don't know if you all know, but often, in programs like A.A., it's okay, and in fact, sort of a place for fellowship for people to go out and smoke, and yet, that turns out not to be doing something good for the behavioral health and strength of those individuals. There are quit lines with tailored protocols for individuals who are suffering from these additional problems, and, as I mentioned, materials available.

So, I know that's really broad and high level, but I'm happy to follow up with any of you offline.

Let's do—I'm going to skip ahead. Please close your eyes while I skip through, just because I know it's annoying to see so many slides go by. There are cardiac rehab slides here, and we also have a group collaborative that is working on improving cardiac rehab. I will leave you with this map. Again, this is the same map of avoidable premature deaths from cardiovascular disease. The yellow triangles are where in Kentucky there are cardiac rehab programs. Interestingly, you see that red area with a paucity of programs.

I'm going to get, here, to my SMBP slides. Alright. So, as I mentioned, self-measured blood pressure monitoring is of major

focus for us in the category of helping people take care of themselves. We have a few other things on the list. I think, likely, all of you are familiar with this, but this is a slide that helps us emphasize, we're not talking about just, individuals just having a monitor. That by itself has not been shown to help achieve blood pressure control and maintain blood pressure control. It is the communion, if you will, of that individual who knows how to operate the monitor, knows good technique, understands what the measurements mean, in communion with the clinician who is eager to get those readings and who generates timely advice back to the patient.

So, we have this wonderful virtuous cycle of readings coming in either on paper or over the web or by phone or fax and advice coming back with adjustments in medications or lifestyle recommendations until that person's blood pressure is under good control. And that's the kind of system that we're trying to advance in the U.S.

I'm sure you know that the new guidelines from ACC and AHA advocate, recommend, strong recommendation for the use of out of office blood pressure measurements to help titrate for those who've been diagnosed, as well as to help make the diagnosis. So, we are now more capable of avoiding overtreatment and undertreatment, masked and white coat hypertension.

So, where are we along the pathway of getting **SMBP** implemented across the country? There are a number of challenges that remain. One is that there's still not a single or even a standard definition of what constitutes SMBP. We are seeing places in the country that are developing protocols, but there is not, of course, yet a universal protocol. There may not need to be, but more consistency in how to implement SMBP would be helpful.

In many places, clinicians distrust readings that come from anywhere except in the office, and frankly, this may be a lack of awareness of the newer publications that show that in-office readings are not likely the best reflection of someone's blood pressure pattern. You need a set of readings that come from more normal parts of that person's life than a reading that can come in the office. We've got a number of health IT limitations getting those readings in, and if you're on the clinician side, the idea of all of your patients with elevated blood pressure sending you multiple pressures a day could blow all of your fuses, just thinking about how you're going to manage all those numbers. So, we need algorithms that take readings in, average and share patterns of

readings, the actionable data with the clinicians who will be making treatment decisions.

Up until recently, patient generated data were not used in quality measures. We know that there is a new measure, a revised measure in the works that will likely incorporate readings from outside the office. That's been a major obstacle.

Making sure that individuals who need blood pressure monitors can get them, regardless of the economic circumstances, is another burden or obstacle to overcome. And then the clinician time to make sure the person knows how to use the monitor, make sure the monitor is validated, and then interpreting those readings and providing that advice.

These are a major subset if not all of the challenges ahead. The good news is that we're making progress. As I mentioned, the guidelines have issued that compelling case for out of office readings. There is a new billing code for remote monitoring of blood pressure and several others in the pipeline. The performance measure, as I mentioned—I'd say that the orange and red items here were further away from the goal line on these, but we are beginning to identify exemplars. And I'll tell you, there are a couple in Kentucky that I'll reference in a minute.

The transfer, though, what I'd like to leave you with is this idea that, in someone who has diabetes, I think most places around the country have gotten really good at helping that individual understand what those blood sugars mean, how to check them, the equipment that they need, and how to communicate those numbers back. It may not be perfect, but enormous amounts of energy and effort have gone into that.

Think about the difference with blood pressure. Often, when someone comes in, they may not even be told what their blood pressure is. Blood pressures that are elevated are tolerated. We attribute them to trouble in the parking lot or the patient having to wait in the waiting room, and that patient goes long times without getting feedback on those numbers. And the clinicians are in the dark, because they're not getting readings except the ones that occur in the office.

So, helping individuals with hypertension master their blood pressure, become the masters of their blood pressure, is a challenge we're vanquishing.

So, the good news here is that there is a national steering committee of experts that we pulled together. They have envisioned the country where everyone who needs it can get SMBP. We've developed a forum for those who are very interested in helping advance this practice. That forum meets by phone quarterly and I have some contact information in the slides, if you'd like to join.

So, what's happening in Kentucky? I feature here three health centers who have been involved in a product who implement SMBP. There's a lot of information on the slide. There's a lot to celebrate, here. Two-thirds of the people in these community health centers who were recommended for SMBP actually used it, and you see the quote from Stephanie Moore—they saw a 5 percent increase in blood pressure control in 6 months. And that translates to 350 Kentuckians with their blood pressure newly under control. This was done in communion, if you will, with a Y that has a community based program, to get back to that question earlier about community connections, and also, of course, with the Department for Public Health, and you see the other partners there.

The tricks of the trade or some takeaways here are listed on the slide. The beautiful thing is, each of these health centers implemented **SMBP** largely in their own way, but the bullet points on this slide were done across all three, by choice, following a written protocol—making sure that the staff were trained to execute that protocol bringing in additional team members (specifically, community health workers) and you see they all used the CARE Collaborative blood pressure log and those wonderful materials.

Alright. So, I wanted to make sure that you got the link to a video which describes the work of these three community health centers. Actually, these are the three health center networks, one set in New York, in Kentucky, and in Missouri. It is a long video, and I gave you the link or the time at which Lighthouse Clinics is featured, but if you have 11 minutes and change to spare at some point, please take a look at this.

This map shows federally qualified health centers overlaying, again, on that avoidable heart disease. And good news is that you likely are already partnering with FQHCs, but there is a fair density of those in that red area of Kentucky. And again, I know I'm not telling you anything that you don't know.

So, I trunk with that, I might be a shade over time. Let me just say that the next couple of slides are about what Kentuckians might consider doing, and I hope that some of this content might be of additional value to you in your breakout sessions today or in your work that comes after.

The first is really about taking care of yourself. I won't walk through each of these, I know they are well known to you. Air quality is something new for us, and I realize we all know that it is quite variable across geography, but if there are air quality issues in your area, I put a couple of slides about particulates into the resource section of this slide deck, and I'm happy to talk to any of you about that further if it is relevant for you.

Health care professionals—this is a clip from that optimizing care set of strategies.

Community members and public health experts—really developing the comprehensive tobacco policies in your communities, including e-cigarettes. Many of you likely saw the publication this week saying that e-cigarettes are not being shown to help smokers quit. So, and particularly when it comes to the enormous uptake by youth and young people, our policies certainly need to be modified to make sure that they include e-cigarettes. The other things here today have to do with healthy design of your community and getting access to space and improving awareness of air quality.

This linkage of health systems and community resources—I come from a clinical background, and I trunk I am a great example of someone who didn't know any of the resources in my own community, despite 25 years of practice there. So, I am living a life now of trying to make those linkages' value very obvious and build more of them

And then health systems leaders—definitely, by setting the expectations for the teams of high performance. The strategies are there. The evidence is strong. It is the implementing of those evidence based strategies that is the challenging and often lengthy part.

One thing we know for sure—people in clinical, clinical staff aspire to take great care of the people they serve. Helping them do so is what this structure is all about.

And then, as an employer, I know that employers have been around the task force table and all of your organizations. So, we

tried to tee up here things that employers can do to ensure the health of their employees, to make the easy choice the default—or make the healthy choice the default. And again, I think most likely, employers in your area are doing this.

One of the things we've found that's not happening universally is the access to free blood pressure monitors, and certainly, the self-insured employers can do this right out of the gate. Commercial payers are beginning to understand that this is a drop in the bucket in tens of an expense and will have long term returns. We have some references on our website about the cost effectiveness of blood pressure monitors for hypertensive patients, so please make use of those if that may be helpful

And then I'll close with some requests and some announcements. We have this cardiac rehab collaborative and also the SMBP forum that meet on phone calls quarterly. Contact information is in the slide deck. Paula had a couple of resources, the Hypertension Control Change Package, which includes protocol examples, information about hiding in plain sight, finding everyone who has this condition and might be in your system but below the radar, videos, and guides. And then, we do have a micro-site, which is a way to embed our material on your website, and when we add something to our website, it automatically appears on yours. So, please avail yourself of that, and there's a slide in the deck about that.

In mid-September, we will be releasing publicly a Cardiac Rehab Quality Improvement Change Package. We'll also be releasing CDC's *Vital Signs*, that shows, by state, the number of Million Hearts events that occurred in 2016 and what we can do about that—what we can all do about that. And then we'll be announcing another crop of champions later this fall

So, thank you very much. I think we might be at time. Jill, let me turn everything back over to you.

*Jill:*

Great. Thank you, Janet. Can you hear me?

*Janet Wright:*

I can.

*Jill:* Great. So, we have a question from the audience, which is—what is the best recommended praxis for validating home blood pressure monitors?

*Janet Wright:* Yes, I would refer you to a guide that is on our website. It's an SMBP guide for clinicians. There's also one for public health professionals, and it collects the evidence that describes how to validate monitors.

*Jill:* Okay. Thanks, Janet.

*Janet Wright:* Sure.

*Jill:* Okay. Any other questions from the audience?

*Janet Wright:* You know, Jill, I'm realizing—I hope later in the day or maybe earlier and I missed it, but there are also an enormous number of wonderful resources available through Target BP, the AHA/AMA program, and AMA also has a wonderful video how-to on SMBP that I think has also migrated to the Target BP site. So, hopefully, none of you will have to create any of those from scratch. You may want to adopt it or adapt it for your own purposes, but hopefully, between all of the folks working on this, we've provided something of value for you.

*Jill:* Hey, Janet, we have another question. I'm sure this is not the first time you've gotten this one. So, cardiac rehabs take a lot of effort and resources to set up, and they're identifying that there's a problem in the availability of these centers to many of these patients. How can we overcome the limitations of things like funding, expertise, resources, et cetera?

*Janet Wright:* Oh, that's a great question! Bless you, whoever asked that question! What everyone realizes—and this is 30 years of literature on cardiac rehab, is that, one of the things that's well-recognized is, there will always be obstacles for an individual to go to a place one hour, two or three times per week, leaving at home all the

people and all the chores and possibly the work that that individual would otherwise be doing, especially overcoming some anxiety about exercising after an event or a procedure.

And so, there's tremendous interest and finally action in developing cardiac rehab delivery models that can be delivered remotely or virtually. Kaiser and the VA have run remote or tele cardiac rehab programs for years. Their results are the same as their brick and mortar facilities; they still do brick and mortar delivery as well.

And so, there are a number of obstacles to overcome, but I know that CMS is certainly interested in understanding how to deliver cardiac rehab remotely. They're interested in telehealth generally, and so, I think the wheels are beginning to turn. A number of commercial payers are now covering tele rehab, or at least a few. We know of a program at Henry Ford in communion with Blue Cross/Blue Shield of Michigan where they are doing virtual cardiac rehab sessions.

So, part of the work of a subset of folks on the collaborative is to understand what actually works and what could translate into a policy that would be able to allow people with Medicaid and Medicare—Medicare Advantage—to receive those benefits and what would help programs deliver this in a really efficient way.

*Jill:* Great. Thank you, Janet.

*Janet Wright:* Yep.

*Jill:* Additional questions? Okay, and then Janet, I also got a note that the video is going to actually play here over lunch, so everybody will get a chance to see that.

*Janet Wright:* Awesome! I cry every time I watch it.

*Jill:* [Laughter]

*Janet Wright:* It's just a piece of beautiful story there, so I'm so delighted. And, again, thank you, all for the work that you're doing. I hope your day is wildly productive. Please let any of us on the Million Hearts team know if we can assist you in your efforts.

*Jill:* Great. Thank you, Janet, and for everybody else in the room, let's take some time to thank Janet for her time today. [Applause] Have a great rest of your day, Janet.

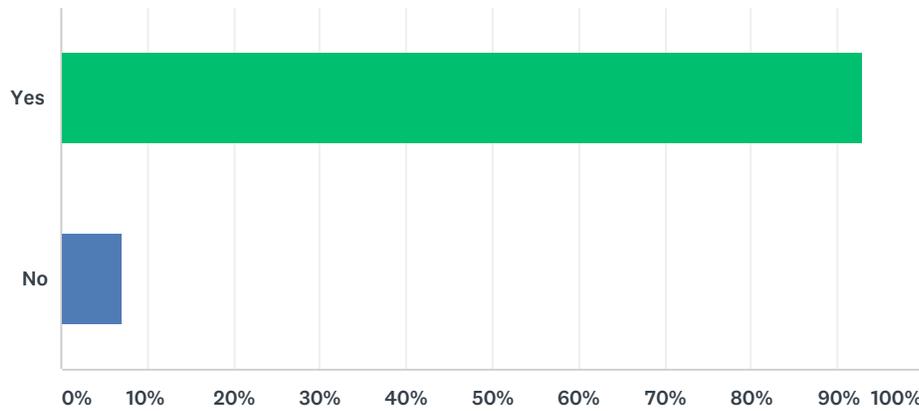
*Janet Wright:* Thank you, Jill

*Jill:* Bye.

*[End of Audio]*

# Q1 Did you attend the Kentucky Heart Disease and Stroke Prevention Task Force held on July 11, 2018?

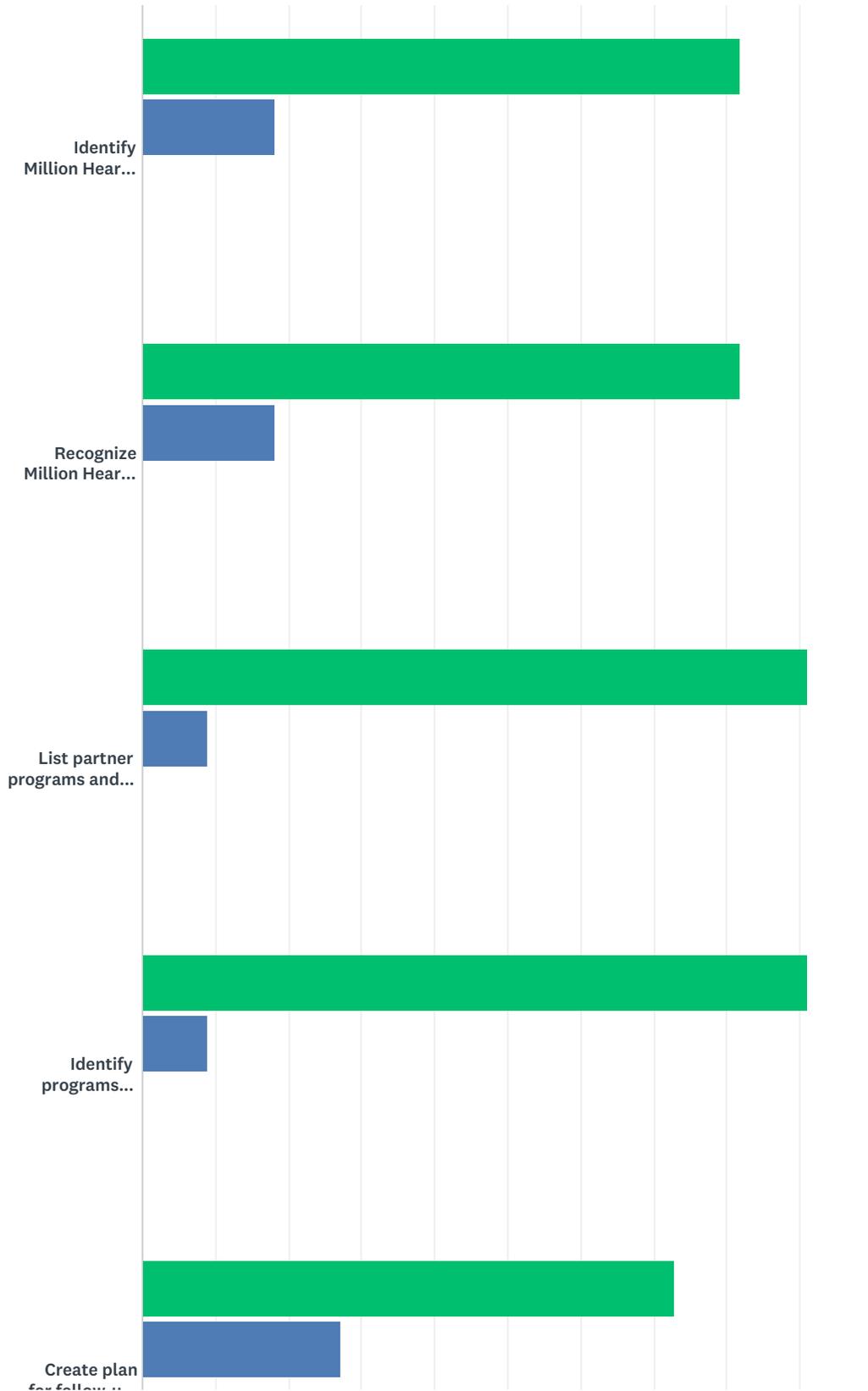
Answered: 14 Skipped: 0



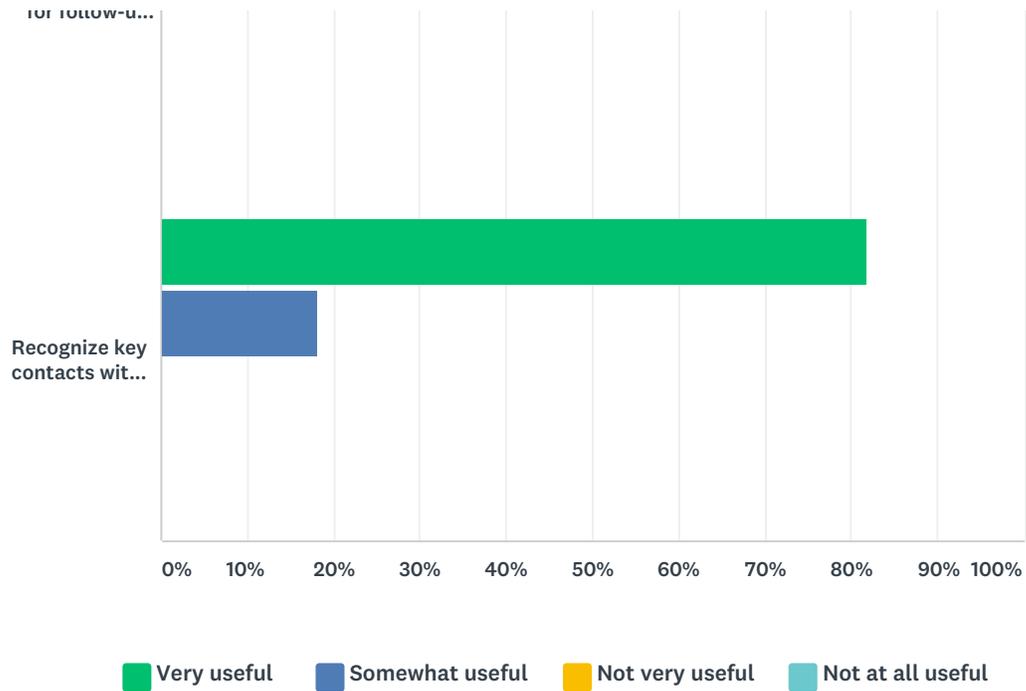
ANSWER CHOICES	RESPONSES	
Yes	92.86%	13
No	7.14%	1
TOTAL		14

## Q2 How useful do you think the information about Million Hearts® provided in this meeting was related to the following objectives:

Answered: 11 Skipped: 3



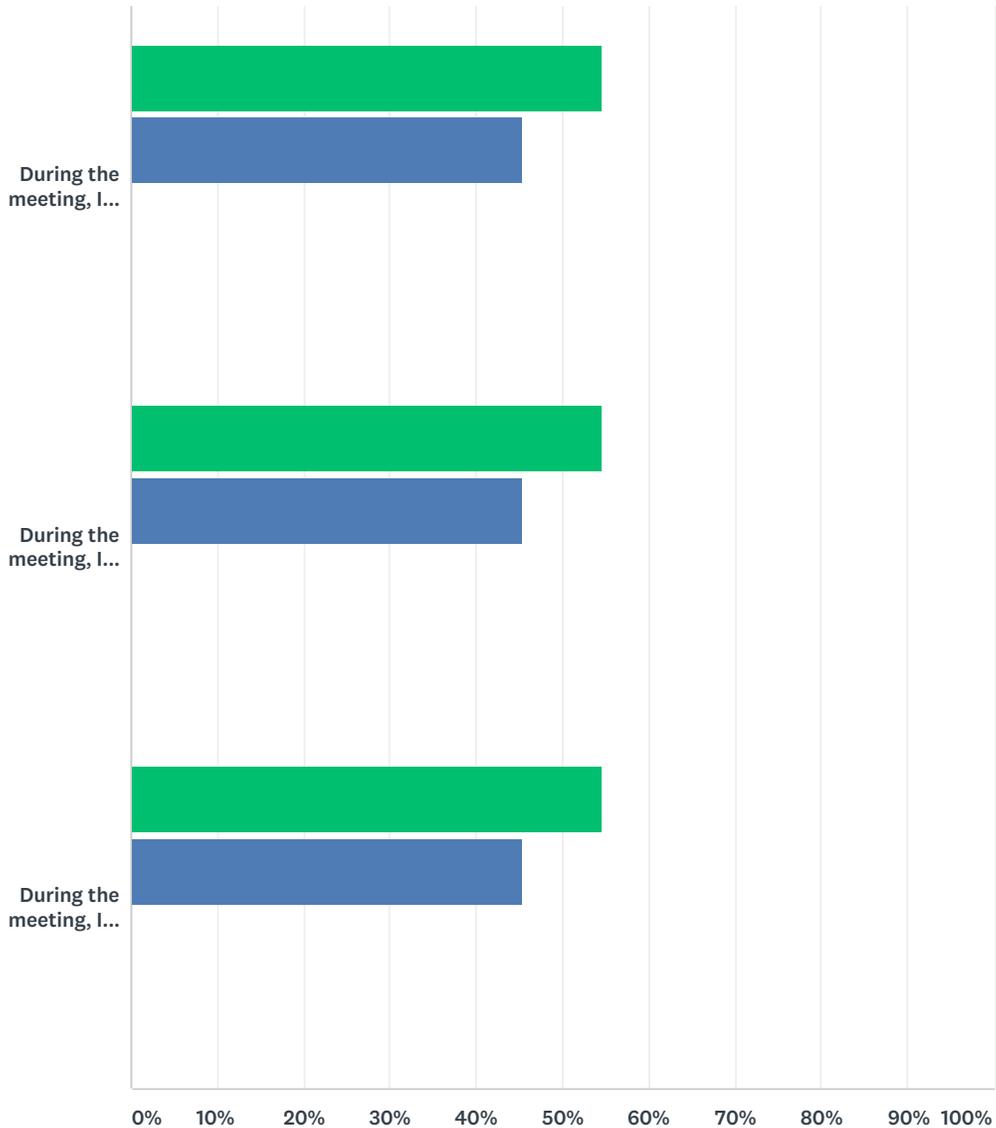
## Meeting Evaluation: Partners Working Together in Kentucky



	VERY USEFUL	SOMEWHAT USEFUL	NOT VERY USEFUL	NOT AT ALL USEFUL	TOTAL	WEIGHTED AVERAGE
Identify Million Hearts focused activities for 2018	81.82% 9	18.18% 2	0.00% 0	0.00% 0	11	1.18
Recognize Million Hearts® evidence-based and practice-based CVD prevention strategies and approaches	81.82% 9	18.18% 2	0.00% 0	0.00% 0	11	1.18
List partner programs and resources that align with Million Hearts®	90.91% 10	9.09% 1	0.00% 0	0.00% 0	11	1.09
Identify programs efforts that align and ways to work together	90.91% 10	9.09% 1	0.00% 0	0.00% 0	11	1.09
Create plan for follow-up to increase engagement	72.73% 8	27.27% 3	0.00% 0	0.00% 0	11	1.27
Recognize key contacts within heart disease and stroke prevention	81.82% 9	18.18% 2	0.00% 0	0.00% 0	11	1.18

### Q3 Please rate the following statements regarding your experience at the meeting.

Answered: 11 Skipped: 3



■ Strongly Agree 
 ■ Agree 
 ■ Disagree 
 ■ Strongly Disagree

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
During the meeting, I identified opportunities to align my work with Million Hearts priorities.	54.55% 6	45.45% 5	0.00% 0	0.00% 0	11	1.45
During the meeting, I identified opportunities to align my work with other partner organizations.	54.55% 6	45.45% 5	0.00% 0	0.00% 0	11	1.45
During the meeting, I identified actionable next steps.	54.55% 6	45.45% 5	0.00% 0	0.00% 0	11	1.45

## Q4 In your opinion, what was the most valuable part of the Million Hearts® information shared during the meeting?

Answered: 5 Skipped: 9

#	RESPONSES	DATE
1	Networking with other collaborators and sharing information on best practices.	9/4/2018 10:51 AM
2	unk	9/3/2018 8:32 AM
3	Evidence based practices	8/31/2018 3:14 PM
4	Information related to SMBP	8/31/2018 3:14 PM
5	SMBP initiative	8/31/2018 3:02 PM