

*Robin Rinker:*

Good afternoon, everyone. This is Robin Rinker with the Million Hearts team here at CDC, and thank you for once again joining us for our quarterly Million Hearts private partner call.

As a reminder, these calls are your opportunity to stay in touch with what's going on in the initiative here in the federal sector, but also what's going on amongst our many partners, and a great opportunity for you to contribute to the initiative. So, we hope to have all of you contribute presentations in the future, and updates today and on future calls. So, there will be some time set aside at the end for you to share what's going on in your world, should you wish to do so.

And, as a reminder, this event is being recorded for rebroadcast, and you will have access to the recording and the transcripts when they're available. We'll make sure to e-mail you and let you know when those are available for your use.

We encourage you to submit written questions at any time during your presentation using the Q&A panel at the bottom right of your screen. So, after typing your questions in the space, you can hit the Send button. Your questions will not be seen by the audience, but will be addressed by the panelists as time permits during the Q&A session at the end of the webinar.

So, today, we will be covering best practices in linking community and clinical sectors. So, we're gonna discuss the Million Hearts Collaboration Community Clinical Linkages Toolkit, which just hit the streets, and highlight effective strategies to help public health practitioners implement community clinical linkages. We'll also provide a springboard from which partners can see their organizations or constituents partnering with similar programs to address community clinical linkages.

We're really grateful to have a great lineup of speakers, once again. Our own Janet Wright, Executive Director of Million Hearts, is gonna lead us off here in a minute; Kitty Bailey, Executive Director of Be There San Diego and Elizabeth Bustos, who's the Director of Community Engagement of Be There San Diego; April Wallace, who you all might have heard from before, our program's Initiative Manager for the Million Hearts Collaboration with AHA; and then Julia Schneider, with the National Association of Chronic Disease Directors and Jennifer Cooper of the Association of Public Health Nurses.

So, you all have bios for each speaker in the agenda, so I encourage you to take a look at those when you have a moment, and at this point, and at this point, I'm gonna turn it over to Janet Wright, to give an overview of community clinical linkages and how they align with Million Hearts.

*Janet Wright:*

Thank you so much, Robin, and welcome, everybody. We are so excited to hold today's call and literally unveil this Community Clinical Linkages Toolkit. I'm just gonna share with you that when I first heard this was going to be produced by the Million Hearts Collaboration, I was extremely excited about it. The mission has always been to fill whatever white space there might be with a tool or resource that is missing, and I think the group in the collaboration identified this as a real opportunity to fill a gap.

But when I realized that Robin and others had given me a few minutes on this call, I had to dig a little deeper about why community clinical linkages were important, or what about it made it feel so important to me. And, you know, I see everything through a Million Hearts lens, and I'm just guilty as charged. I think you all know about me—if it's the evening news or the way the sun comes up or the weather, I'm trying to interpret that in terms of what that means for preventing heart attack and stroke and improving cardiovascular health. So, guilty as charged.

But, when it comes to community clinical linkages, there were three specific things that resonated with me that connected this work and this toolkit, actually, to the initiative. And the first is that, even by its name, community clinical linkages is about public health and health care working really well together in a complementary way—bringing our best game to each other for the benefit of people with and at risk for heart disease. So, clinical community, for me, resonates with public health and health care.

Secondly, the Community Clinical Linkages Toolkit is about implementation. I think we've all recognized that producing something, a guide, a guideline, a document, even a toolkit is great, but it's not the end game. The end game is getting those things that we know work into settings—community or clinical—where they will have the impact on the population and the population's health. So, implementation is the hard thing, and that's what this toolkit is meant to provide—guidance and a roadmap or an on ramp to implementation.

And then, the final part of this Community Clinical Linkages Toolkit that so deeply resonates with me is that we have real life

examples, and that's what today's call is all about. You are going to hear from people who are living the linkage. I think about Elizabeth Bustos, I think about Julia and Jennifer and Kate, all of whom you're going to hear about today. What they're going to share with you is not theoretical, it's not concepts—it's where it's happening on the ground. And what we hope is that this toolkit is both something that you will find valuable, that you will be able to adopt it, and more importantly, that you can adapt it for the people that you serve, for the communities and clinical settings where you work.

So, with that, I'm just, again, very grateful for all of you joining today. I know this will be a powerhouse set of presentations, and I'm very happy to turn it over, now, to Elizabeth Bustos.

*Elizabeth Bustos:*

Good afternoon, everybody. Hello from Be There San Diego. It is a pleasure to be with you this afternoon, and thank you so much Janet for all you do for Million Hearts and our community, and I must say what you do for Elizabeth Bustos as well, because your calling card is passion, and you know we have passion here in San Diego.

I have the privilege of introducing you to and sharing the story of Be There San Diego, and really also sharing about our project, our community clinical linkages project, the Southeastern San Diego Cardiac Disparities Project.

First, if I may, a little bit about Be There San Diego, and the mission of Be There is to eliminate heart attacks and strokes in San Diego. We have a shared vision—create a heart attack and stroke-free zone. And if I may, really, at its core, Be There San Diego is a coalition of communities, health care organizations, health plans, the county, Health and Human Services, and so many others working to eliminate heart attacks and strokes by reducing cardiovascular risk—including controlling hypertension and preventing diabetes.

This audacious goal is driven by Be There San Diego's strategic framework, and it's really four core areas—health care team activation, health care system activation, community activation, and community clinical linkages.

And so, this is what our four focus areas look like. With community clinical linkage intervention, we engage community pharmacists, engage community health workers, and develop bidirectional referral recommendations. We also promote

partnerships between faith-based organizations and the clinicians we work with.

Under the clinical interventions focus, we promote the use of the ASCVD risk calculator, also promote the use of the cardiovascular risk medication bundle, and we promote that team-based care, including pharmacists, the care team, health coaches, and we also test innovative technologies for cardiovascular risk.

Under the health systems intervention focus area, we share intermediate outcomes data between medical groups, assess and promote the use of clinical decision support tools, promote pharmacy integration across the health care system, and really support linkages between the clinical community and public health community. We've also worked on developing a payment model to support population health.

And then lastly, the community interventions piece. We engage faith-based organizations in creating heart health PSEs—policy, systems, and environmental changes. We promote the use of community blood pressure screenings, promote home blood pressure monitoring, and then really work hard under the umbrella of raising awareness of cardiovascular disease risk factors.

So, now this is really an opportunity for me to pivot and share the story of Be There San Diego's Southeastern San Diego Cardiac Disparities Project—I know that's a mouthful at times—funded by the CDC's Racial and Ethnic Approaches to Community Health. It is a faith-based community linkages project with a lot of heart. It's the project that speaks the language of the community. Community clinical linkages in Southeastern San Diego means that the work is at the crossroads of community, medicine, and justice.

So, what is our goal? For the last four years, our goal has been to improve the cardiovascular health of African-American adults in Southeastern San Diego through increased healthy behaviors and the management of risk factors to end heart attacks and strokes in the historically underserved, under resourced Southeastern region of San Diego, the city of San Diego. Here in our community, really when we think about goals, we're really talking about we speak to the covenants. We speak with our community partners and our community residents we serve.

Our objectives? Increase awareness of cardiovascular risk factors, increase referrals from faith-based organizations to clinicians, and increase medication initiation and adherence.

So, what was the response of the Southeastern San Diego faith community? We came in talking about community clinical linkages, we came in talking about best practices, but this is what their response looked like to us. “We believe that each person is born with dignity and divinity with purpose. Chronic heart disease has robbed so many of us in our community of the greatest joy of fulfilling their purpose. We will no longer sit idly by. We will be there for every member of our community to lift them to their greatness in health.”

Now on this journey, understanding community context was essential, and what we didn't know, we had to learn fast. In Southeastern San Diego, the black church is really the center of community life. Our pastors and imams are really our community CEOs. They are in the unique position to incorporate health messages into churches and mosque activities. They are in the best position to engage congregants and inspire them to act. We know the black church has an important, rich legacy of activism.

Our lens? Health equity as a civil rights issue. The work is about social justice, and it's about those non-negotiables, and it's also about trust, and acknowledging and dealing with the historical traumas, the deep rooted hurts associated with racism—and yes, the deep rooted hurts associated with racism in medicine.

The project's call to action became no one—absolutely no one should die of a preventable disease. Every conversation was hard fought. In large meetings, in private ones, community members and health care providers listened to each other's experiences. This extraordinary dialogue has opened the doors for doctors to better understand their patients, and vice versa. And this is really significant, given the lack of trust between them.

We know there's still much homework to do on the trust front, and there must be constant vigilance. But this, we also know—friendships and trust have been forged.

Ah! So, what have the results been? So, we have 22 churches and a mosque all getting together and forming a faith-based learning community for resource sharing and capacity building. Each completed its own heart health plan of PSEs to raise awareness of risk factors, manage chronic disease, and support those linkages to the physicians.

And this is, you know, where I really need to pause and honor, you know, our dear, dear partners at American Heart Association who came into our community, rolled up their sleeves, and really became the leaders, and in the toolkit that was so much needed by our community residents. It's just been a wonderful, wonderful experience.

So, here are the PSEs by the numbers—66 interventions implemented across the 22 faith-based organizations, 22 doing blood pressure monitoring, 22 healthy food policies, and then of course, the physical activity interventions.

The data is still being collected, but just last year, there were 826 self-reported referrals to patients, to clients, congregants, to physicians, and if they had problems and barriers accessing clinical care, the teams were there to assist them.

Okay. If you spend a little time in our community, you know we love to name names. You know, and this slide just really shows the 22—I wanted to share with you the 22 partners who have stuck with us since the beginning, really opened their hearts and minds to us, trusted us to be able to have the courage to share the hard conversations, have trusted us to bring physicians into the community and host them for hard conversations around—yes, taking your medicine, why don't you take your medicine? Trusting us to really say, "We're looking for partners, and we're dying. Our community is dying, and we will no longer stand idly by and let this happen."

With that, I want to thank everybody for listening to our story, and this is just—you know, I always worry, when we put together a slide that shows our partners, because these are our partners, and there's just so much, so many more partners and organizations who have lifted the voice of Be There San Diego, the residents of Southeastern San Diego, and the clinician partners as well. And I think—I'm hoping, this is my contact information, we're always happy to share our story. Ours is an open book. We absolutely listen and learn with open hearts and minds, and even though we know and we recognize that the work being done here around community clinical linkages is very, very special, we also know we are a work in progress and there's so much more we need to learn.

And so, here's my contact information. Thank you very much for the opportunity to share our story, and with your permission, I'd like to toss it over to April Wallace.

*April Wallace:* Thank you so much, Elizabeth. What an inspiring mission. Today, we are so excited to share with you this new resource, the Community Clinical Linkages Toolkit. This toolkit, it organizes an array of resources, and it helps, really, to help public health practitioners develop and strengthen effective community clinical linkages. We didn't seek to recreate the wheel, we wanted to make sure that we could compile a storehouse of information and resources that would be most valuable to our public health practitioners.

So, I just wanted to just—a couple of quick thank yous. The toolkit has been produced by what is known as the Million Hearts Collaboration, and that collaboration is kind of a subset of the larger Million Hearts partner network, and it's 14 organizations that we really work collaboratively together to disseminate evidence-based resources around cardiovascular disease prevention, and we really wanna promote the use of consistent cardiovascular health messaging and providing opportunities for sharing of best practices and evidence-based prevention approaches. Hence, this very important toolkit that we have put together, and we are presenting to you today.

So, we want to give a special thanks to all of our Million Hearts Collaboration members, especially Julia Schneider, who will speak next, and Miriam Patanian of the National Association of Chronic Disease Directors, for leading this important effort and this working group that put together the toolkit.

Additionally, just a special thank you to our other contributing organizations, including the AHA, APHA—which you will hear from Jennifer Cooper—and then ASTHO, the Association of State Territorial Health Officials, and National Association of County and Health City Officials, and also the National Forum, and the Ohio State University.

So, these organizations really contributed much of their time and energy to helping us identify resources and review documents that have been included in this toolkit, and we extend a special thank you for your efforts.

So, without further ado, I will hand it over to Julia Schneider, who will share more details about the Community Clinical Linkages Toolkit.

*Julia Schneider:* April, thank you so much. We are so pleased to launch the Community Clinical Linkages Toolkit today. This has been quite a

collaborative effort this past year to put this together for everyone on the line, and we hope that you find this to be a useful resource. I'm so excited about Janet's introduction to it and, obviously, Elizabeth's inspiring presentation, and so, we can't wait for everyone to be able to use these resources.

We really see this as a resource for public health departments and their partners to advance the Million Hearts mission and to address cardiovascular disease in your states and communities. As mentioned, Million Hearts has truly brought together so many exciting new efforts and new programs to states and communities through collaboration between public health, primary care, community clinics, and community-centered organizations, and this is another tool for you to use in your work.

When you go to the website, you will see components of the Practitioner's Guide for Community Clinical Linkages for the Prevention and Control of Chronic Diseases, such as the definition of community clinical linkages. It also defines the community sector, the public health sector, and the clinical sector. The Practitioner's Guide presents strategies that involve practitioners from the public health sector who are leading efforts to link the community and clinical sectors.

We know this work is so critical in your states and communities, and we wanted to provide you with real, on the ground resources, as everyone has mentioned. The Community Clinical Linkages Toolkit has been developed to help public health practitioners like everyone on the phone and your partners around the country implement the seven, step by step linkage strategies that are highlighted in the Practitioner's Guide. And you can see them on your screen. Learn about community and clinical sectors. Identify and engage key stakeholders from community and clinical sectors. Negotiate and agree on goals and objectives of the linkage. Know which operational structure to implement. Aim to coordinate and manage the linkage. Grow the linkage with sustainability in mind, and evaluate the linkage.

So, each of these seven strategies, the Community Clinical Linkages Toolkit provides resources that were obtained from many of the organizations that April had mentioned and also those organizations helped to identify additional resources. And they helped implement each strategy. The resources have links and brief descriptions of their contents through a drop-down menu.



Wherever possible, the originating agency's description of the resource has been used—and again, this was totally a collaborative effort among all the organizations of the CCL working group to collect and then prioritize these resources that would fit the strategies. And we were very mindful of the fact that there's a lot of resources out there, and we really tried to provide a nice subset that was the most useful.

In the toolkit you will find resource lists, white papers, case studies, examples of referral and tracking forms, and clinic checkoff lists, strategies that demonstrate how to incorporate community health workers, community pharmacy programs, and primary care. There's resources that address the use of electronic health records and data to identify areas of need and activate funding sources. There's examples from state health department, examples of data sharing agreements, resources from federal organizations such as AHRQ and CDC, such as the Health Equity Resource Toolkit, and the AHRQ Community Clinical Relationship Measures.

There's resources from NACDD with success stories and descriptions of the Million Hearts stakeholder meetings that we held, resources from ASTHO's Million Hearts learning community, resources from the Cleveland Clinic, guidelines and assessment tools from the Preventive Cardiovascular Nurses Association, and a training module from NACCHO on engaging partners, stakeholders, and community members. And then we also have resources from partners such as the American Public Health Nurses Association and the Ohio State University, which you will hear from today.

As April mentioned, there's a number of organizations that helped contributed to the toolkit. We have them named here, and we just wanna thank everyone for your hard work, and we're just really, really pleased to be able to launch this today.

I will now turn this over to Jennifer Cooper of the Association for Public Health Nurses, who will share one of the resources in the toolkit and how it translates to the field and engaging communities.

*Jennifer Cooper:*

Thank you, Julia, and hello to everyone. This is Jen Cooper. I'm from the Association of Public Health Nurses, and the Association of Public Health Nurses represents nurses who are practicing in public health and the community sectors. So, it is really important for us that we are linked to nurses and providers in the clinical

sector. And I've included some tools that—sorry, I just wanna switch slides, here. Go forward. Okay.

I've included some tools here today from the toolkit that showcase, on a smaller scale, some community clinical linkage activities related specifically to Million Hearts, and I want to tell you a bit more about this work today.

APHN's commitment to Million Hearts is all about educating our members on Million Hearts and the role that they play as nurses in the community and in public health settings. So, I'm gonna focus a lot on that role, but an important part of these community programs is that we plan, we deliberate plan a way to know when and how that we can refer patients or participants to the clinical sector for further evaluation and treatment—that's very important.

So, two ways in particular that APHN has been able to showcase their role of nurses in the community that are working to advance the goals of Million Hearts is (1) through our work with the Meritus Health Parish Nurse Network. The Meritus Health is the health system in Western Maryland, and this network, what we did is, we provided both data analysis and dissemination with their project. And I just want to note that this network is a network of licensed nurses working in states and communities, and what they did is provide free home monitors, education on how to do self-monitoring or home monitoring with the blood pressure monitor, they provided face to face coaching on lifestyle changes, and they were very effective in reaching those who providers in the clinical sector may not be able to reach because of that importance of the relationship and trust factor that exists in the states and communities.

The other project is that I worked to develop an academic nursing project, and enlisted the help of student nurses to connect us with other national nursing partners to identify ways we could advance Million Hearts. One of these partners, who you will hear from shortly, is the Ohio State University's College of Nursing and Dr. Kate Gawlik.

So, I teach community health nursing at Hood College in Frederick, Maryland, and I initially worked with an RN to BSN student to make the connection with the Ohio State Million Hearts Fellowship modules. And these modules are in the grow section of the toolkit, so you'll be able to see that, and Kate will also talk to you about that. We wanted to make them accessible to our

members, so we did that, and then we also used these modules to train two other pre-licensure nursing [Audio skips].

So, I wanted to share this model for healthy blood pressure, which we used in both projects, it's been very popular. It was actually created by the Meritus Health Parish Nurse Network, and we used it for both projects, as I said. It represents the American Heart Association's Simple Seven, which are the steps to make heart healthy lifestyle changes. So, we had participants self-assess in each area, all seven areas, pre- and post-, and then we also had them choose one to two areas that they would specifically focus on. And this gave us something to focus on during our coaching sessions in the community, whether it was in the faith communities or on our college campus through the nurse and the student nurses.

So, this tool was published in a 2016 article that I'm gonna share with you next, but I wanted to show you that tool, and these—like I said before, education here is really key for the nurses, but dissemination is also key. The articles I've displayed here describe the implementation and the outcomes of the Meritus Health Project. We had 109 participants altogether. It was published in a peer reviewed journal, *Public Health Nursing*, and we presented it at several conferences—APHN, the American Public Health Association, NACCHO, and the 2017 article is under the grow section in the toolkit. We also did a logic model that helped us create and plan the project, and that's in the 2016 article. It's also in the negotiate session of the Community Clinical Linkages Toolkit.

And I'm currently working with Meritus Health right now to write a chapter in a faith community nurse text using Million Hearts as an exemplar. So I really encourage you to disseminate the work that you're doing around Million Hearts.

The Hood College Project just piloted this summer, our project. We had 20 participants, and we're gonna continue that into the coming academic year with two brand new students, and we are working on a manuscript to describe Advancing Million Hearts through an academic nursing project and hope to present that at academic nursing conferences so that other schools of nursing can use this, both as a learning tool for their students, but also as an outreach to their community.

So, I thank you for your attention today, and I'm now gonna turn this over to April Wallace and the American Heart Association.

*April Wallace:* Thank you, Julia and Jen, so much for your just continued work, especially with this community clinical linkages working group, and thank you for sharing that tool, Jennifer.

So, now we are, we've come to the Q&A portion of the webinar. Again, if you have questions for our panelists, please submit your questions in writing using the Q&A panel located at the bottom right of your screen. And we've had a couple of questions come in as our speakers have been talking, and so I'll start here.

The first question that we have is—I think this is gonna be for Elizabeth. “I would love to learn more about what care the pharmacists are referred patients for, and how their services are reimbursed.”

*Elizabeth Bustos:* Hello? This is Elizabeth. I'm sorry, I heard Elizabeth and then pharmacist. I apologize—can you please repeat the question?

*April Wallace:* Sure. It says, “I would love to learn more about what care the pharmacists are referred to patients for, and how their services are reimbursed.”

*Elizabeth Bustos:* My goodness, I really—that’s such a good question, and true confessions? This afternoon, I was going to be joined by Kitty Bailey, our Executive Director for Be There, and she was specifically going to be able to speak to the pharmacy referral piece and those connections, and she’s not able to join me. And I would not want to speak to or provide an answer that would be incorrect. And my—do I have your permission; can I take that back?

*April Wallace:* Sure.

*Elizabeth Bustos:* And is there going to be a reach out to the organizers, have an opportunity to report back with greater detail?

*April Wallace:* Absolutely. Those questions that we're not able to get to or need some additional time, we will report back to those individuals who asked for those questions, mm-hmm.

*Elizabeth Bustos:* Thank you.

*April Wallace:* No problem. Our next question is, “Do you plan to add to the resources and update as needed for the CCL toolkit, and will there be any training on use of the toolkit for practitioners?” So, I guess, Julia, we can kinda tag team this one.

Short answer is that we do plan to update this toolkit as needed. We are gonna go—it'll be updated, you know, on a continuous basis. And so, our working group is dedicated to really kind of doing the follow up to make sure that the resources that are in the toolkit are up to date.

That's a really good question about training and use of the toolkit for practitioners, and I don't really have a good answer for that, at the moment. Any thoughts about that, Julia? *[Laughter]*

*Julia Schneider:* No, but these are all great ideas, and if others have ideas, I think we can just collect them and kinda think about next steps as we continue to add resources and think about how to help states and communities use the toolkit, so thank you for that question.

*April Wallace:* Absolutely. Alright. Our next question, "What options are available to provide free blood pressure monitors for our hypertensive patients to monitor their blood pressure at home?" I would think that may be Elizabeth's?

*Elizabeth Bustos:* Yes. I can share with you options and, really, realities that took place here with our project in San Diego is that, you know, one of our treasured partners, Kaiser Permanente, funded American Heart Association to enter our community and do education and provide blood pressure monitoring and for our clients and patients to be able to do that at home, and also in a church based setting.

But again, that was through our partner, Kaiser, who really saw firsthand the good work that was being done, and then came in and asked, "What resources do you need, you know, to keep the REACH project going?" The other thing that they did is—and actually, that funding came through their Check. Change. Control. signature program, so those resources are available. They've been available to us, but—so, it does happen. I'm hoping I'm answering your question.

But that was our experience. The American Heart Association, Kaiser Permanente came into our community and was inspired by the work that they saw, quickly understood that the very first thing that needed to happen was that we needed to equip their churches, and we needed to equip our congregants, and they stepped up to the plate.

*April Wallace:* Thank you, Elizabeth. Our next question is probably for you as well—“What could insurance plans do to help facilitate community clinical linkages?”

*Elizabeth Bustos:* I'm sorry, can you say the first part of your question?

*April Wallace:* “What could insurance plans do to help facilitate community clinical linkages?”

*Elizabeth Bustos:* Oh, man, that's such a good question, because we just now began to tap into the various health plans, and I have to say that the very first thing that we are seeing is, they have to please take us up on the opportunity to come to our community and see firsthand not only the work that's being done, okay, but also see firsthand that we also happen to be in one of the most underinsured and under resourced communities, and they have resources.

And so, I think having a presence is essential. Don't wait for invitations, you know, particularly with the Kaisers of the world, we have Aetna, we have Blue Shield. They're at the table, but again, everything is theory until we have those representatives come out and not only present about what they do, okay, but also engage in doing the linkaging themselves.

Am I answering your question? You have to have a presence.

*April Wallace:* I think that answers the question. Again, if you have any questions, please be sure to submit those in the right-hand bottom of your screen in the Q&A panel.

Another question, here, “Could you”—Elizabeth, this is for you. “Could you describe further how you got members of the community to engage with churches and talk about some of the potential challenges encountered for sustained community clinical linkages?”

*Elizabeth Bustos:* Thank you. Gosh, that's the story of our project right there in that question. You know, as I shared earlier, we knew we had to engage the pastors, our community CEOs, and unless we had buy-in from them, we couldn't start the conversation.

And something very interesting happened—even, you know, once the pastors came on board, another lesson that we learned is that community residents and congregants were actually afraid to come in and have the conversations. There was some serious fear about coming in, the thought of ideas about being judged, ideas about

being reminded that they've got cardiovascular disease, hypertension. "You're gonna tell me, give me unreasonable things that I need to do, like change my food, change physical activity, take my medication and I have serious trust issues with that."

So, what we did is, literally, by invitation to the pastors, we integrated and embedded into the day to day activities of the church, whether it was Bible study, we had a presence; whether it was, certainly, Sunday services. And we attended as many Sunday services as possible. We were given an opportunity to actually present on the pulpit about heart health, and about mind, body, and spirit.

And, again, it can be stressful, and it takes a lot of resources, but picking up the toolkit and being willing to have the conversation in environments that matter to community residents—being able, making those commitments to show up for Bible study, show up for fellowship after church. And, as I keep saying, sustained presence is sustained presence. Because what we've learned is that community members want to see us in their environment.

They're kinda turning the tables around. You know, too frequently, we ask them to come into our clinical setting, to come into our exam room. You know, well, that's just half of the conversation. They want to see us in their home. They want to see us in their environment, in their own comfort zone to see how we behave, see how we keep our covenants, our promises. And again, it goes back to having a sustained presence.

I'm hoping I'm answering your question.

*April Wallace:*

Well, it's a really good answer. *[Laughter]* We have time for a couple of more questions. The next question we have—this is for you, Jennifer. "The evaluation of different approaches is essential for understanding what works. Could you speak to a little bit more about your research projects and the involvement of student nurses and more information on how you're using your research with your students?"

*Jennifer Cooper:*

Oh, that's a great question. So, it was really a two-fold project that we did. One is to make sure that the students are well trained and feel comfortable, not just with helping participants monitor their blood pressure, but also educating them on how to make changes in their life and connecting them to the resources that they need.

But what we did, and the students were involved in collecting this data—which Kate will, I think Kate will speak a little bit more about Million Hearts screenings. But collecting that data, collecting pre- and post- data so that we could see if that intervention of the students sitting face to face with someone and coaching them and saying, “You can do this, you know, have you increased your physical activity?” if that’s what they chose to work on, “Have you changed your eating a little bit?” if that’s what they chose to work on. So, that face to face time was what we hoped would make a difference.

And we looked—so, we looked at the data pre- and post- and then the other part of that is just, the students are actually coming with me to our in person collaboration meeting in August to present the work that they did. They also have a lot to share. You know, of course, they have participants that were really, really motivated and some that weren’t so motivated.

But one thing that was really positive for us, too, was the incentive of being able to give them a free home monitor and showing them how to use it. So, even if, after that, they weren’t as motivated, at least they had the tools in their hands and they knew how to use them.

So, the students do work and look at the data pre- and post- and the comparison and then I do have them help me put together a manuscript and a presentation and think about dissemination as well.

So, hopefully that answers your question. Thank you for asking.

*April Wallace:*

Again, thank you to all of our panelists for your really inspiring presentations today, and thank you to all who have asked questions regarding these presentations.

So, we'll move right along right now. We are gonna open up, again, the chat box. If you have any updates that you'd like to share from your organization, please submit your update in writing using the Q&A panel at the bottom right of your screen, and I will share your responses as time permits. And again, if those updates are not shared in this webinar, we will have a follow up e-mail that will include all of the updates that are submitted by our partners.

We also have another Million Hearts partner who will start us off with partner sharing and sharing some additional information about another resource that’s been included in our Community Clinical



Linkages Toolkit. So, we're gonna start with Kate Gawlik from the Ohio State University College of Nursing. Kate, are you there?

*Kate Gawlik:*

I am. Thank you so much, April, and thank you so much for having me be a part of this call. I also am very excited to share with you about the resources that we have put together, and I'm also very excited about the toolkit that is now available for usage.

So, like April said, my name is Kate Gawlik, and I am an Assistant Professor at the Ohio State University College of Nursing, and I have been fortunate to work with Dr. Bernadette Melnyk, and together, we have put together what is called the Million Hearts Fellowship Module. And when Million Hearts started back in 2012, we sat and we were thinking about how we could help to disseminate this out into—across the United States.

And what we came up with was a free online educational module. And this module is designed for health sciences professionals, health sciences students. We also have a slightly different module that's for community members. And what we do is, we have providers and community members, whoever is interested, we have them come onto our educational module, and it's a four step process.

So, first, what we do is, we have them watch a series of lectures. So, these lectures go over things like, "What is Million Hearts?" and then how to do what we call a Million Hearts screening. So, we want this to look uniform, you know, whether somebody's in Maine or Ohio, California—we want it to all look very similar.

And what this screening entails is a height and weight and a body mass index calculation of blood pressure, and in some cases but not all, cholesterol. And then a lot of emphasis on education—so, teaching people about the ABCs of Million Hearts and really getting that individualized patient education.

So, what happens is, the provider comes online, they watch a series of these lectures on how to do Million Hearts screenings. Then they go out into their community and they screen and educate. We ask at least 10 people. So, these can be, you know, embedded into curricula, so we have a lot of academic institutions that have embedded this module into their curricula, into their population health courses or community health courses. We have people that just go out and will do it at their churches, or some people will do it at their practices. You know, so it's applicable pretty much

across the spectrum of health care, but again, you can kinda see that, the linkage between that community and that clinical.

So, once they do that, we just ask that they track some outcomes. So, this is all de-identified data, so, things like their gender, their age, their blood pressure—just so we can, like Jen was saying, track our outcomes and see what we've found.

And then the person, they input this into our online educational module following the screenings, and then they do a 10 item post-test and they're certified as a Million Hearts fellow. So, for example, at Ohio State, all of our nursing students go through this module by the time they graduate. So, we're seeing on all their résumés, you know, Million Hearts fellow, which is really great to see.

And so, it's provided a really wonderful opportunity for us to take these things and maybe get to people that don't have access to regular care. You know, so it's very easy to use, and like I said, it's online, and it's free for anyone.

So, you can see the information, go to this website, you select Million Hearts fellow, and then you create an account, and you have access to the program. So, it's very easy to use, and I would encourage anybody that is interested or they think that they have a place for this in whatever setting there is, you know, to go on and try it out.

And—yeah, we're very excited about it. Through this process, we've been able to screen over 65,000 people now across the nation. So, we're really excited about those numbers.

Okay, and I'm going to pass it on now to Robin.

*Robin Rinker:*

Alright. Thanks, everyone. We wanted to share just a few updates from our corner of the world, and our most important thing that we have coming up is, we have a *Vital Signs* report due out on September 6th about Million Hearts. And so, every month, CDC puts out a *Vital Signs* report that details new data about a disease that has a huge impact on the American public. And so, we're really excited and grateful that, in September, we will be featuring Million Hearts 2022. And, for the first time, we will have some state level Million Hearts event data that we will be able to share, as well as all the details about what we can do about this and what Million Hearts is doing to address cardiovascular disease in the country.

So, again, that is out on September 6th. There will be some new data, there will be a bunch of communication materials for you to read and use and promote, and we have a special ask of you all, actually. So, Judy Hannan is here in the room with me, and I'm gonna ask her to say a few words to that end.

*Judy Hannan:*

Sure. Thank you, Robin. So, the run up to *Vital Signs*, everything is kept close hold until the day of when partners may get a couple hour notice of what the *Vital Signs* actually says. But you all are well aware of what is happening in your community from a cardiovascular standpoint. There will just be some numbers reported—we're very excited about that.

What I'd like, my ask of you is—be prepared to tell your story about what you're doing. The local media pickup often has to do with whether there's a local story that somebody can talk about, so this is a heads up. Have your agency, your story ready, make sure your people up the chain know that it may be a news story right after Labor Day as far as the preventability of heart attacks and strokes and people might be looking for those sort of successes.

So, as much as I can ask you to just sort of be ready and be opportunistic, there should be an opportunity for you to think about some local bragging.

*Robin Rinker:*

Thanks, Judy. *Vital Signs* always makes a big media splash, and so this is an exciting opportunity not just for us, but for you all as well to talk about and celebrate your work in the Million Hearts area.

So, with that, I'm gonna turn it back over to April for the closing. I know we are just about at time.

*April Wallace:*

Thank you, Robin and Judy, for those updates. And thank you, all, for joining us today. Thank you for your time, and I'd like to, again, thank our presenters and those organizations who provided updates. Though we did not get a chance to get to all of the updates from our partners, we will include those in a follow up e-mail to you.

As well, the Community Clinical Linkages Toolkit is available, it does have a webpage, and we will include that address in our follow up e-mail as well for you all to go and view those resources and use them as applicable.

Thank you, again, for today. Our next partner call is gonna be scheduled for October 16th at 1 p.m. Eastern Standard Time. We look forward to you joining us then, and for now, have a good day. Thank you.

*[End of Audio]*