Advancing Million Hearts®
AHA and Heart Disease and Stroke Prevention
Partners Working Together in Montana

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

Table of Contents

Contents
Meeting Summary ................................................................................................................................................................... 3
What excites you about your work in heart disease and stroke prevention? ................................................................. 5
Agenda .................................................................................................................................................................................... 6
Presentations: ......................................................................................................................................................................... 8
Million Hearts® 2022 Update ............................................................................................................................................... 9
Montana Department of Public Health and Human Services ............................................................................................. 9
American Heart Association .............................................................................................................................................. 10
Mountain Pacific Quality Health ....................................................................................................................................... 11
Managing Chronic Conditions in a Changing Healthcare Environment ............................................................................ 12
Increasing Patient Engagement in Hypertension and Hypercholesterolemia Management ........................................... 13
Increasing Community Supports for Self-Management of Hypertension and Hypercholesterolemia ....................... 13
Breakout Group Discussions: ................................................................................................................................................ 15
Group 1: Increasing Patient Engagement in Hypertension and Hypercholesterolemia Management ............................. 16
Group 2: Increasing Community Supports for Self-Management of Hypertension and Hypercholesterolemia ............ 19
Post-Meeting Evaluation Summary ........................................................................................................................................ 22
Attendee List
Event Presentation Slides ...................................................................................................................................................... 28
Partner Profile Summary ....................................................................................................................................................... 46
Meeting Summary

**Goal:** The goal of the meeting was to develop a coordinated and integrated strategy for managing blood pressure and cholesterol to prevent and control co-morbidities in Montana.

**Objectives:**
1. Increase awareness of Million Hearts® strategies and activities for 2020
2. Increase stakeholder awareness of the links between hypertension/hypercholesterolemia and co-morbidities such as dementia
3. Develop strategies to increase community supports for patient management of hypertension and hypercholesterolemia
4. Identify strategies to increase patient engagement in managing hypertension and hypercholesterolemia

**Outcome:**
Attendees will initiate plans to align and sustain efforts to manage hypertension and hypercholesterolemia in Montana.

**Overview**
On September 17, 2020, 48 representatives from 22 health organizations devoted to reducing the prevalence of heart disease met to develop a coordinated and integrated strategy for managing blood pressure and cholesterol to prevent and control co-morbidities in Montana. This was the 12th Advancing Million Hearts® and the second to be held virtually.

The meeting was designed to help participants increase their knowledge of existing hypertension efforts, initiate opportunities for collaboration and share success and lessons learned with peers. Speakers provided national, state, and local perspectives on preventing and managing cardiovascular disease risk factors and co-morbidities. This included tools and resources available through the Million Hearts® initiative; hypertension initiatives through the Montana Department of Public Health and Human Services, the American Heart Association and Mountain-Pacific Quality Health; and the link between hypertension and dementia. Clinic staff also shared their successes and lessons learned through implementing strategies in their settings.

Participants separated into breakout groups to share information about their organizations’ hypertension management efforts and identify potential alignments to (1) increase patient engagement in managing hypertension and hypercholesterolemia and (2) increase community supports for patient management of hypertension and hypercholesterolemia. Approximately 58% of meeting attendees participated in the first breakout group, and 42% participated in the second.

Participants concluded the breakout sessions by sharing key takeaways and next steps. The following themes emerged for overcoming challenges and guiding next steps:

- Using videos to educate patients how to take their own blood pressure
- Using team-based care
- Using clinic hotspots and devices to provide telehealth services to patients who might not have broadband or a cellphone
• Exploring remote patient monitoring; establishing protocol for pharmacists and care team members; and sharing the results statewide
• Implementing peer education strategies for providers
• Purchasing accurate blood pressure devices
• Educating patients on proper device usage
• Engaging with payers to demonstrate successes to implement change/movement towards value-based care

Montana will continue moving hypertension and cholesterol improvement efforts forward in a coordinated manner. Potential avenues include:
• Mountain-Pacific Quality Health will collaborate with interested health systems on remote patient monitoring options.
• The MT DPHHS will highlight successful primary care interventions at Montana’s Million Hearts Workgroup meetings.
• Primary care clinics are encouraged to participate in Mountain-Pacific Quality Health’s Learning and Action Network on topic-specific chronic disease management.

Approximately 25 of the 48 participants responded to the post meeting evaluation survey. Overall, respondents indicated the presentations and discussions were very useful or somewhat useful in meeting the day’s objectives. Approximately 67% of survey respondents identified new organizations with which to partner and feedback reflected an appreciation to hear from partners working in the field. A Post-Meeting Evaluation Summary is provided later in the document.
What excites you about your work in heart disease and stroke prevention?

<table>
<thead>
<tr>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educating patients on lifestyle changes</td>
</tr>
<tr>
<td>Decreasing preventable deaths in Montana</td>
</tr>
<tr>
<td>Offering evidenced-based care to my patients</td>
</tr>
<tr>
<td>Working with our partners on stroke and blood pressure efforts, we can improve and save lives</td>
</tr>
<tr>
<td>Patient engagement</td>
</tr>
<tr>
<td>I love having direct patient care to improve medication adherence and medication regimens for chronic disease states</td>
</tr>
<tr>
<td>Having the resources and contacts to help cardiac rehabilitation programs optimize their capacity and reach and providing science translational tools to improve the quality of cardiovascular care services</td>
</tr>
<tr>
<td>The ability to have proactive and upstream impacts on outcomes</td>
</tr>
<tr>
<td>The opportunity to learn and then to guide community pharmacists in helping people lead healthier lives</td>
</tr>
<tr>
<td>The opportunity to assist patients with health lifestyle change and use medication management to help patients reach their personal health goals</td>
</tr>
<tr>
<td>Meeting communities where they are and supporting community efforts to address overall health and well-being while advancing health equity</td>
</tr>
<tr>
<td>Ability to improve the quality of life of people</td>
</tr>
<tr>
<td>Working with our clinical team on ways to promote self-management and optimal outcomes for our patients</td>
</tr>
<tr>
<td>Help organizations and individuals magnify their collective impact</td>
</tr>
<tr>
<td>Driving changes to policies and systems to reduce cardiovascular health disparities</td>
</tr>
<tr>
<td>Bringing partners together across various sectors and finding synergies</td>
</tr>
<tr>
<td>I love empowering patients and helping them activate their own role in improving their health</td>
</tr>
<tr>
<td>Helping people live healthier lives</td>
</tr>
<tr>
<td>Broad statewide initiatives to better improve cardiovascular care in rural and underserved communities</td>
</tr>
<tr>
<td>Getting to design and disseminate tools whose implementation can impact the health trajectories for thousands of people. Small changes have a big effect when applied across the U.S. population</td>
</tr>
<tr>
<td>Being able to look back and see the progress we are making in treatments and prevention</td>
</tr>
<tr>
<td>Partnership we have with our cardiovascular group and the overlap of work we have for both diabetes and CVD</td>
</tr>
<tr>
<td>The potential to create positive behavior change among individuals that lead to better choices and improved physical and mental well-being</td>
</tr>
<tr>
<td>Reducing death and disability from CVD</td>
</tr>
<tr>
<td>Finding innovative ways to improve patient care and engagement</td>
</tr>
<tr>
<td>Making an impact in our communities for healthier lives</td>
</tr>
<tr>
<td>The ability to intervene sooner and prevent serious complications from poorly treated hypertension and hypercholesteremia</td>
</tr>
<tr>
<td>The ability to help people live healthier lives</td>
</tr>
<tr>
<td>Enabling medical facilities to provide the best possible care</td>
</tr>
<tr>
<td>Cardiovascular prevention is a key piece for population health and healthier communities. I am excited to learn more of the steps we can take for our community to prevent heart disease and stroke both within the Health System and innovative partnerships within the community</td>
</tr>
</tbody>
</table>
## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item/Topic</th>
<th>Speaker/Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:15 – 8:45 am</td>
<td>Pre-meeting Partner Networking</td>
<td>John Bartkus, PMP, CPF Principal Program Manager, Pensivia</td>
</tr>
<tr>
<td></td>
<td>Participants connect/meet in a few rounds of randomly assigned virtual rooms to network</td>
<td></td>
</tr>
<tr>
<td>8:45 – 9:00 am</td>
<td>Please Join no later than 8:50 am Verify Zoom Audio/Video working, and Vevox App setup on your phone</td>
<td></td>
</tr>
<tr>
<td>9:00 – 9:10 am</td>
<td>Welcome Overview of the Day</td>
<td>John Clymer Executive Director, National Forum for Heart Disease and Stroke Prevention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sharon Nelson, MPH Program Initiatives Manager, Million Hearts® Collaboration</td>
</tr>
<tr>
<td>9:10 – 9:35 am</td>
<td>Engagement &amp; Introductions</td>
<td>John Bartkus</td>
</tr>
<tr>
<td></td>
<td>Introduction to key materials, engagement process (polls and Q&amp;A), and Introductions</td>
<td></td>
</tr>
<tr>
<td>9:35 – 10:05 am</td>
<td>Million Hearts® 2022 Update Q&amp;A</td>
<td>Laurence Sperling, MD Executive Director, Million Hearts®</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lauren Owens, MPH Public Health Analyst, Million Hearts®</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Haley Stolp, MPH Public Health Analyst, Million Hearts®</td>
</tr>
<tr>
<td>10:05-10:40 am</td>
<td>Montana Hypertension Initiatives and Resources</td>
<td>Crystelle Fogle, MBA, MS, RD Manager, Cardiovascular Health Program</td>
</tr>
<tr>
<td></td>
<td>• Montana Department of Public Health &amp; Human Services</td>
<td>Jessica Newmyer Community Impact Consultant</td>
</tr>
<tr>
<td></td>
<td>• American Heart Association</td>
<td>Patty Kosednar, PMP, CPHIMS Account Manager</td>
</tr>
<tr>
<td></td>
<td>• Mountain-Pacific Quality Health Q&amp;A</td>
<td></td>
</tr>
<tr>
<td>10:40-10:45 am</td>
<td>Stretch Break</td>
<td>Jen Childress, MS, MCHES Jenspiration, Inc. Senior Public Health Consultant</td>
</tr>
<tr>
<td>10:45-11:05 am</td>
<td>Hypertension and Dementia Q&amp;A</td>
<td>Jim Richards, MD St. Vincent Healthcare</td>
</tr>
<tr>
<td>11:05-11:40 am</td>
<td>Managing Chronic Conditions in a Changing Healthcare Environment</td>
<td>Laurence Sperling, MD Executive Director, Million Hearts® Eduardo Sanchez, MD, MPH Chief Medical Officer, American Heart Association</td>
</tr>
</tbody>
</table>
## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item/Topic</th>
<th>Speaker/Facilitator</th>
</tr>
</thead>
</table>
| 11:40 – 12:00 pm | Patient engagement in hypertension and cholesterol management Q&A | Angela Jennings, RN-BC  
Primary Care Nurse Manager, Bozeman Health |
| 12:00 – 12:20 pm | Community Supports for self-management of hypertension and hypercholesterolemia Q&A | Aimee Grose, RN, Clinical Care Leader  
Libby Kyllo, BS, RRT, Community Health Worker  
Bridging Health and Home Program  
Sanford Health, Mayville Medical Center |
| 12:20-12:50 pm | Lunch                                                       |                                                                                   |
| 12:50-12:55 pm | Activity Break                                              | Jen Childress                                                                      |
| 12:50 – 2:05 pm | Breakout Sessions                                           | John Bartkus                                                                      |
| 2:05 - 2:15 pm | Break                                                       | John Bartkus                                                                      |
| 2:15 – 2:35 pm | Group Report Outs                                           | Julie Harvill, MPA, MPH  
Operations Manager, Million Hearts® Collaboration |
| 2:35 - 2:45 pm | Summary of Common Themes/Strategies                         | Crystelle Fogle                                                                   |
| 2:45-2:55 pm   | Next Steps                                                  |                                                                                   |
| 2:55-3:00 pm   | Adjourn                                                     | Laura King  
Director of Public Health, American Heart Association |

### What does Success Look Like?

![Image of Montana with words like policy, solutions, collective, action, and tools]
Presentations:
The following are highlights of presentations shared by meeting participants. The full presentations can be found at the end of the report.

Million Hearts® 2022 Update

- Laurence Sperling, Executive Director, Million Hearts® Division for Heart Disease and Stroke Prevention, CDC
- Lauren E. Owens, Public Health Analyst, Million Hearts® IHRC, Inc.
- Haley Stolp, Public Health Analyst, Million Hearts® IHRC, Inc.

Impact of Pandemic on Cardiovascular Care
Emergency physicians are seeing declines in the number of patients arriving with cardiac problems.

Current Challenges/Concerns
- 118 million Americans living with Hypertension
- Disruption of Ambulatory care
- Need for Medication Access and Adherence
- Impact on lifestyle implementation
- Disruption of cardiac rehabilitation

Million Hearts® Updates
- CDC Foundation Campaign
- Million Hearts 1.0 Addendum
- Hypertension Control Champions
- Cardiac Rehabilitation Think Tank
- AMA/ AHA Scientific Statement SMBP
- AMA validatebp.org
• JCRP & JAMA Cardiology invited commentaries
• CMS promotes V-BID in Final Payment Notice for 2021
• Reinvigorating 100 Congregations
• Updated Hypertension Control Change Package
  o Includes 253 tools from 87 organizations
  o Capitalizes on 7 years of MH Hypertension Control Champions
  o Features more self-measured blood pressure monitoring (SMBP) resources
  o Explores potentially undiagnosed hypertension
  o Added new strategies that focus on chronic kidney disease (CKD) testing and identification
  o Provides more patient supports for lifestyle modifications
• Million Hearts® Cardiac Rehab Collaborative
  o Joining efforts to reach 70% CR participation by 2022
  o Quarterly calls of reps from ~200 organizations
  o CR professionals, health care team members, QI specialists, hospital and health system administrators, public health professionals, payers, and innovators
  o Shared ‘action plan’ of objectives; report progress
    1. Increase awareness of the value of CR among health systems, clinicians, patients and families, employers, payers
    2. Increase use of best practices for referral, enrollment, and participation
    3. Build equity in CR referral, participation, and program staffing
    4. Increase sustainability, affordability, and accessibility through innovations in program design, delivery, and payment
    5. Measure, monitor, and report progress toward the CRC aim

Montana Department of Public Health and Human Services
Crystelle Fogle
Cardiovascular Health Program Manager
Key Blood Pressure Focus of Grants

- Undiagnosed Hypertension
- BP Quality Improvement
- Team-Based Care
- Medication Therapy Management
- Self-Measured Blood Pressure Monitoring

American Heart Association
Jessica Newmyer, Community Impact Consultant

Target: BP

- Customize a plan using MAP Framework
  - Measure accurately
  - Act rapidly
  - Partner with patients, families, and Communities to promote self-management and monitor progress
- Measure Improvement and Report Result
- Strive for Recognition at 70% or higher
Current Initiatives

1. Improve Behavioral health outcomes, including opioid misuse
2. Increase patient safety
3. Improve chronic disease outcomes/self-management
4. Improve care transitions
5. Improve nursing home quality
6. Implement age-friendly health care systems
7. Transition from fee-for-service (FFS) to value-based payment models
8. Assist quality reporting
9. (Quality Payment Program’s Merit-based Incentive Payment System [MIPS] and Alternative Payment Model [APM])

Hypertension and Dementia

James Richards, MD, Stroke Medical Director
St. Vincent Healthcare
Dementia Risk Factors

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

Managing Chronic Conditions in a Changing Healthcare Environment

- *Eduardo Sanchez, Chief Medical Officer*
  American Heart Association
- *Laurence Sperling, Executive Director, Million Hearts®*
  Division for Heart Disease and Stroke Prevention, CDC

People of any age with certain underlying conditions are at increased risk of severe COVID-19

- Chronic kidney disease
- COPD
- Immunocompromised from solid organ transplant
- Obesity (BMI ≥ 30)
- Serious heart conditions (HF, CAD, cardiomyopathies)
- Sickle cell disease
- Type 2 DM

COVID-19 Mortality

Compared to White people, the age-adjusted COVID-19 mortality rate for:

- Black people is 3.8 times as high
- American Indian/Alaska Native people is 3.2 times as high
- Pacific Islander people is 2.6 times as high
- Hispanic/Latino people is 2.5 times as high
- Asian people is 1.5 times as high.
Increasing Patient Engagement in Hypertension and Hypercholesterolemia Management

Angela Jennings
Primary Care Nurse Manager, Bozeman Health

- The RN-Pharmacist Hypertension Clinic started in January 2019
- The team consists of 8 RNs and 8 Clinical Pharmacists
- 38 Practitioners have signed the compact agreement
- Year to date: 240 patients have participated in the program
- 82% of the patients are at goal within 9 weeks
- After graduating, patients receive a follow up phone call every 3 months for the first year
- Continue to expand the program

Increasing Community Supports for Self-Management of Hypertension and Hypercholesterolemia

Aimee Grose, Clinical Care Leader
Libby Kyllo, Community Health Worker
Sanford Health, Mayville Medical Center
The Bridging Health and Home program (BHH)
Model of Care
- Nurse-led community-based clinic
- Faith community nursing principles of intentional care of the spirit

Funding and locations
- Mayville, ND
- Webster, SD
Breakout Group Discussions:
Meeting participants selected one of the following discussion sessions in which to participate.

<table>
<thead>
<tr>
<th>Group</th>
<th>Topic</th>
<th>Co-Facilitators</th>
<th>Notetakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Increasing Patient Engagement in Hypertension and Hypercholesterolemia Management</td>
<td>Patty Kosednar</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Increasing Community Supports for Self-Management of Hypertension and Hypercholesterolemia</td>
<td>Mike McNamara, Amber Rogers</td>
<td></td>
</tr>
</tbody>
</table>

The following notes were taken during each discussion.
**Group 1: Increasing Patient Engagement in Hypertension and Hypercholesterolemia Management**

**Breakout Group Questions**

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

- **Facilitator(s):** Marilyn McLaury, Patty Kosednar
- **Notetaker:** Courtney Buys

**Group Questions:** (~60 mins total)

- What are you doing now? What are the results? (~15 mins)
- What did you learn today that might influence your direction or support you? (~10 mins)
- How does patient engagement change as a result of Covid-19? (~10 mins)
- What challenges/barriers do we have to overcome? (~10 mins)
- How can we address those challenges? (~15 mins)

**Individual Take-aways:** (~5 mins)

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

**Key Take-Aways to Share in Report-Out**

*What are you doing now? What are the results?*

Pre-COVID engagement with fitness facilities. Currently trying to get people who are in pods to go for walks and other physical activity. Can get people there for a week to two weeks but challenging to get folks to buy in long-term. (KRMC)

Maintained need for wellness visits throughout pandemic; providing patient education on why wellness visits are safe and necessary. Older patients are willing to go virtual. Finding ways to encourage activity including Medicare Advantage exercise videos. “Staff is relentless” educating patients about the different ways and places patients can be seen. Tap into care managers as needed. (Providence)

Care management is very involved in calling patients and follow-up. Financial piece is even more seen during pandemic. Less virtual visits and more in-person visits recently at request of patients. Important to have many different “touch points” for patients who can offer different expertise and experience. (Billings)

Piloting “Welldoc” for diabetes self-management services. (DPHHS)

Carehere hypertension program has seen a decrease in enrollment, but still good engagement. The program is already online and engaged remote monitoring.

You cannot have patient engagement without meeting the patient where they are at. E.g. having patient use their own blood pressure monitor for self-monitoring.

*What did you learn today that might influence your direction or support you?*
Innovative ways to engage with nontraditional community groups

Providers refer patients to allied health people (pharmacist, dieticians, care team) who have more time to spend with patient

Care management and motivational interviewing. Medicare annual wellness visits for PCPs, NPs have a full 45 minutes to spend with patients to talk through wellness and prevention.

Virtual peer learning and education as a long-term solution to transportation barriers.

High touch, quick return, model in Bozeman hypertension clinic, to create change quickly.

**How does patient engagement change as a result of Covid-19?**
Increased telehealth, decreased in person visits

**What challenges/barriers do we have to overcome?**
Finding the additional time for someone to spend with the patient.

Broadband, cell service, connectivity with telehealth.

Remote patient monitoring- devices, Bluetooth, takes forever to interface devices into EHR. Hard to separate good and bad.
Creating a common language. Not using clinical speak, translating the important information to language that is universally understandable.

**How can we address those challenges?**
Using videos to educated patients how to take their own blood pressure.

Team care!

Using clinic hotspots and devices to provide telehealth services to patients who might not have broadband or a cellphone.

Communicating or working as a group around remote monitoring and sharing the results statewide.

Utilize resources that might have more bandwidth / expertise to create a common language.

**Key takeaways**
- Better understand if there is any tracking of post COVID complications.
- Bring takeaways back to organization about Bozeman health hypertension successes
- Write up of recommendations from Patient and Family Advisory Council
- Connect with folks doing all of these innovative things to share with frontline folks.
- Think outside of traditional boxes to connect with patients to make health changes
- CDC may be able to provide assistance in connecting folks with other organizations that are not traditional partners; and identify ways to connect best practices both inside and outside of Montana
- AHA excited about collective QI work
The following individuals registered to participate in the breakout discussion:

<table>
<thead>
<tr>
<th>Aimee Grose</th>
<th>Laura King</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alona Jarmin</td>
<td>Libby Kyllo</td>
</tr>
<tr>
<td>Amber Rogers</td>
<td>Lisa Jones Barker</td>
</tr>
<tr>
<td>Amy Emmert</td>
<td>Marilyn McLaury</td>
</tr>
<tr>
<td>Cheryl Stensrud</td>
<td>Melissa House</td>
</tr>
<tr>
<td>Courtney Buys</td>
<td>Mike Lionbarger</td>
</tr>
<tr>
<td>Crystal Menick</td>
<td>Mike McNamara</td>
</tr>
<tr>
<td>Cynthia Armstrong</td>
<td>Molly Wendland</td>
</tr>
<tr>
<td>Debbie Butz</td>
<td>Patricia Kosednar</td>
</tr>
<tr>
<td>Erica Hoversland</td>
<td>Rebecca Atkinson</td>
</tr>
<tr>
<td>Haylie Wisemiller</td>
<td>Roberta Wagner</td>
</tr>
<tr>
<td>James Bennett</td>
<td>Sang-Mi Oh</td>
</tr>
<tr>
<td>James DeFoe</td>
<td>Sarah Elliott</td>
</tr>
<tr>
<td>Jeff Redekopp</td>
<td>Sarah Leake</td>
</tr>
<tr>
<td>Jessie Fernandes</td>
<td>Sharon Nelson</td>
</tr>
<tr>
<td>John Clymer</td>
<td>Susan Morgan</td>
</tr>
<tr>
<td>Julia Schneider</td>
<td>Tessa Tatsey</td>
</tr>
<tr>
<td>Kamesha Ellis</td>
<td>Trina Filan</td>
</tr>
<tr>
<td>Kristen Range</td>
<td>Trish Gilliam</td>
</tr>
</tbody>
</table>
**Group 2: Increasing Community Supports for Self-Management of Hypertension and Hypercholesterolemia**

<table>
<thead>
<tr>
<th><strong>BREAKOUT GROUP QUESTIONS</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is each organization doing?</strong></td>
<td><strong>What’s working?</strong></td>
</tr>
</tbody>
</table>

Facilitator(s): Mike McNamara, Amber Rogers  
Notetaker: Kristen Range

Facilitator guidance:
Lead the group through these five key questions. The group has 65 mins from 1:00 – 2:05pm MDT. Capture your group’s notes on the following section (KEY TAKE-AWAYS TO SHARE IN REPORT-OUT). Those following page(s) will be shared on-screen during group reports back to the main group. Tip - have the person capturing the conversation share their screen (in Zoom) – using this document like a visual flip chart. Leave at least 5 minutes at end for individual take-aways.

**Group Questions:** (~60 mins total)
1. What are you doing now? What are the results? (~15 mins)
2. What did you learn today that might influence your direction or support you? (~10 mins)
3. How does community support change as a result of Covid-19? (~10 mins)
4. What challenges/barriers do we have to overcome? (~10 mins)
5. How can we address those challenges? (~15 mins)

**Individual Take-aways:** (~5 mins)
- What new partners have I identified today with whom I can work to further my/their goals?
- What two actions will I take based on what I learned today?
**KEY TAKE-AWAYS TO SHARE IN REPORT-OUT**

1. **What are you doing now? What are the results?**
   Susan Morgan: Has worked with DPHHS for a couple years. Room for improvement in quality metrics and would like to focus on team-based care. Utilized lunch and learns to work with the team to try and decrease the “silos” that occur. Worked on hypertension with the medical director that believes in hypertension algorithms and created a BP program. Worked with DPHHS to create a QI project to reach target BP to improve outcomes for patients. Ongoing education is moving this project forward. Building a report in to the Health IT platform for undiagnosed HTN (a patient seen in the last year with 2+ BP readings of 140/90 or greater). Goals include, establishing a blood pressure clinic. Barriers include provider buy-in, concerns that it may cause more work. Began CCM about a year ago and that is gaining buy-in from providers.

   Amy Emmert: Significant work with TBC this includes, pharmacist, behavioral health specialists, clinical nutritionist support, and care management. Beginning in October there will be training for consistent accurate BP readings across all care team members. Incorporating automated BP readings with manual readings as the cost allows. Community paramedic program will go to patients’ homes to take BP readings for patients with transportation barriers. Areas of opportunity include culinary arts as a prescription to incorporate healthy foods. Potential partners include the Helena Food Share.

   Jimmy Bennett: The most effective thing with BP program was starting with a daylong seminar for primary care providers across the state. 20-30 people attend the sessions to focus on teaching people how to do accurate BP readings with the most up-to-date technology. This increased awareness of hypertension through the accurate readings. Community pharmacy program (3rd year) this uses a smart phone app to order meds through the app and includes med adherence, education, and reminders. Areas of opportunity include TBC to establish a way for a clinic and community pharmacist to improve outcomes for patients with DM and HTN. Aiming to work with local providers and the community pharmacists that share patients to work together to be able to have a full medication review for the shared patient panel.

   Haylie Wisemiller: Community paramedic team can go to the patient’s homes for wound care, immunizations, and food delivery. Utilizing EMTs to address needs for patients that are frequently in the ER to reduce the EDU rates.

2. **What did you learn today that might influence your direction or support you?**
   Billing codes BP checks, access to self-monitored BP cuffs, how social determinants of health play a large role in managing patients with chronic conditions, telehealth opportunities, provider engagement and role, outreach the Sanford practices are doing, how do we get to the community as a whole and make the population healthier, use the talents across the entire healthcare and community system (utilize TBC!), patient motivation, community
pharmacist establishing talking points to support patients, creating relationships with resources outside the healthcare system (senior centers, churches, food banks, etc.), AHA resources, utilize technology to connect even during COVID-19

3. **How does community support change as a result of Covid-19?**
   Things are difficult but utilizing telehealth has been a big win for patients in a rural setting or with health-related social needs. Community paramedicine program was moved forward quickly due to Covid-19. This allowed for greater outreach to patients.

4. **What challenges/barriers do we have to overcome?**
   Challenges/Barriers: Providers do not feel the at-home BP readings are accurate (can you diagnose based on those readings?), standardization and proactive identification of patients, workload for care team, reimbursement

5. **How can we address those challenges?**
   Provider education (establish a provider champion to start a pilot project and share ideas to spread the change throughout the organization), physician to physician education, utilize remote patient monitoring, purchase accurate devices, patient education on proper device usage, establish a protocol for remote patient monitoring for pharmacists and care team members to follow, data transparency, engaging with payer partners to demonstrate successes to implement change/movement towards value-based care.

**Individual Take-aways:** (~5 mins)
- What new partners have I identified today with whom I can work to further my/their goals?
  - Bozeman Health BP clinic and Sanford Health
- What two actions will I take based on what I learned today?

The following individuals registered to participate in this breakout discussion:

- Courtney Buys
- Crystal Menick
- Erica Hoversland
- James DeFoe
- Jessie Fernandes
- Julia Schneider
- Libby Kyllo
- Lisa Jones Barker
- Marilyn McLaury
- Melissa House
- Mike Lionbarger
- Molly Wendland
- Patricia Kosednar
- Rebecca Atkinson
- Trish Gilliam
- Angela Jennings
- Chandala Curtiss
- Crystelle Fogle
- Haley Stolp
- Jessica Newmyer
- Jill Swenson
- Joe Tabler
- Joel Allen
- Julie Harvill
- Karen Gray-Leach
- Katelin Conway
Post Meeting Evaluation:
Advancing Million Hearts: American Heart Association and Heart Disease and Stroke Prevention Partners
Working Together in Montana
September 17, 2020

Meeting Attendees: 48
Survey Responses: 25

100% of survey respondents thought the meeting was very useful or somewhat useful in meeting its objectives of:

- Increase awareness of Million Hearts® strategies and activities for 2020
  - Very useful: 91%
  - Somewhat useful: 9%
- Increase stakeholder awareness of the links between hypertension/ hypercholesterolemia and co-morbidities such as dementia
  - Very useful: 82%
  - Somewhat useful: 18%
- Develop strategies to increase community supports for patient management of hypertension and hypercholesterolemia
  - Very useful: 91%
  - Somewhat useful: 9%
- Identify strategies to increase patient engagement in managing hypertension and hypercholesterolemia
  - Very useful: 86%
  - Somewhat useful: 14%

67% of survey respondents plan to connect with new organizations as a result of this meeting. Including:

- Bozeman Clinic (6)
- AHA (4)
- Hospital systems
- St. Vincent’s
- CDC
- MT Primary Care Association
- KRMC

100% of survey respondents participated in the Q&A polling. The majority of respondents liked the polling platform and said it was “easy and straightforward to use.” However, one participant noted that there was a delay in the questions and another participant did not like the split between Vevox and zoom. One participant preferred the chat function and polling in Zoom to Vevox.
After attending the meeting, respondents said they plan to explore CVH resources related to:

- SMBP (3)
- Flu shot promotion (3)
- Non-traditional partners and new relationships (2)
- Remote patient monitoring (2)
- Share information within organization
- BP dashboard activity
- Change packet
- Home monitoring
- Identify hidden hypertension
- BP Clinics

Participants felt the most valuable part of the meeting was:

- Presenters (5)
- Updated information (3)
- Information sharing/networking (3)
- Liked remote option (2)
- Bozeman and N Dakota (2)
- Breakout sessions (2)
- Resources
- Information about different interventions

Participants felt the least valuable part of the meeting was:

- Pre-networking (2)
- Breakout sessions
- Technology
- Presentation on dementia
- Lunch break
- No handouts
- Less time from CDC and state speakers
- Lost in some of the medical terminology
### Attendee List:

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Organization</th>
<th>Job Title</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aimee</td>
<td>Grose</td>
<td>Sanford Health</td>
<td>RN Clinical Care Leader</td>
<td><a href="mailto:aimee.grose@sanfordhealth.org">aimee.grose@sanfordhealth.org</a></td>
</tr>
<tr>
<td>Alona</td>
<td>Jarmin</td>
<td>Mountain-Pacific Quality Health (MPQHF)</td>
<td>Senior Account Manager</td>
<td><a href="mailto:ajarmin@mpqhf.org">ajarmin@mpqhf.org</a></td>
</tr>
<tr>
<td>Amber</td>
<td>Rogers</td>
<td>Mountain-Pacific Quality Health (MPQHF)</td>
<td>Account Manager</td>
<td><a href="mailto:arogers@mpqhf.org">arogers@mpqhf.org</a></td>
</tr>
<tr>
<td>Amy</td>
<td>Emmert</td>
<td>St. Peter's Health</td>
<td>Senior Director of Population Health</td>
<td><a href="mailto:aemmert@sphealth.org">aemmert@sphealth.org</a></td>
</tr>
<tr>
<td>Angela</td>
<td>Jennings</td>
<td>Bozeman Health</td>
<td>Primary Care Nurse Manager</td>
<td><a href="mailto:ajennings@bozemanhealth.org">ajennings@bozemanhealth.org</a></td>
</tr>
<tr>
<td>Chandala</td>
<td>Curtiss</td>
<td>Providence Health and Services</td>
<td>Manager of Population Health</td>
<td><a href="mailto:chandala.curtiss@providence.org">chandala.curtiss@providence.org</a></td>
</tr>
<tr>
<td>Cheryl</td>
<td>Stensrud</td>
<td>St. James Healthcare</td>
<td>Health Outcomes Improvement Manager</td>
<td><a href="mailto:cheryl.stensrud@sclhealth.org">cheryl.stensrud@sclhealth.org</a></td>
</tr>
<tr>
<td>Courtney</td>
<td>Buys</td>
<td>Montana Primary Care Association</td>
<td>Health Outcomes Improvement Manager</td>
<td><a href="mailto:cbuys@mtpca.org">cbuys@mtpca.org</a></td>
</tr>
<tr>
<td>Crystal</td>
<td>Menick</td>
<td>Southern Peigan Health Center</td>
<td>FNP</td>
<td><a href="mailto:cmenick@blackfeetnation.com">cmenick@blackfeetnation.com</a></td>
</tr>
<tr>
<td>Crystelle</td>
<td>Fogle</td>
<td>Montana Department of Public Health and Human Services (MT DPHHS)</td>
<td>Program Manager</td>
<td><a href="mailto:cfogle@mt.gov">cfogle@mt.gov</a></td>
</tr>
<tr>
<td>Cynthia</td>
<td>Armstrong</td>
<td>Northwest Physicians</td>
<td>RN, CHC</td>
<td><a href="mailto:cynthianwp@gmail.com">cynthianwp@gmail.com</a></td>
</tr>
<tr>
<td>Eduardo</td>
<td>Sanchez</td>
<td>American Heart Association</td>
<td>Chief Medical Officer for Prevention</td>
<td><a href="mailto:eduardo.sanchez@heart.org">eduardo.sanchez@heart.org</a></td>
</tr>
<tr>
<td>Erica</td>
<td>Hoversland</td>
<td>Billings Clinic</td>
<td>Clinical Pharmacist</td>
<td><a href="mailto:ehoversland@billingsclinic.org">ehoversland@billingsclinic.org</a></td>
</tr>
<tr>
<td>Haley</td>
<td>Stolp</td>
<td>Centers for Disease Control and Prevention (CDC)</td>
<td>Public Health Analyst, IHRC Inc.</td>
<td><a href="mailto:hstolp@cdc.gov">hstolp@cdc.gov</a></td>
</tr>
<tr>
<td>Haylie</td>
<td>Wisemiller</td>
<td>St. Peter's Health</td>
<td>Population Health &amp; Community Education Specialist</td>
<td><a href="mailto:hwisemiller@sphealth.org">hwisemiller@sphealth.org</a></td>
</tr>
<tr>
<td>James</td>
<td>Bennett</td>
<td>Transforming Chronic Care</td>
<td>Pharmacist consultant</td>
<td><a href="mailto:jbennett@jbaweb.com">jbennett@jbaweb.com</a></td>
</tr>
<tr>
<td>James</td>
<td>Richards</td>
<td>St. Vincent Healthcare</td>
<td></td>
<td><a href="mailto:james.richards@sclhealth.org">james.richards@sclhealth.org</a></td>
</tr>
<tr>
<td>Jeff</td>
<td>Redekopp</td>
<td>Quality Health Associates of North Dakota</td>
<td>Quality Improvement Specialist</td>
<td><a href="mailto:jredekopp@qualityhealthnd.org">jredekopp@qualityhealthnd.org</a></td>
</tr>
<tr>
<td>Jessica</td>
<td>Newmyer</td>
<td>American Heart Association</td>
<td>Community Impact Consultant, Western States</td>
<td><a href="mailto:jessica.newmyer@heart.org">jessica.newmyer@heart.org</a></td>
</tr>
<tr>
<td>Jessie</td>
<td>Fernandes</td>
<td>Montana Department of Public Health and Human Services (MT DPHHS)</td>
<td>Section Supervisor</td>
<td><a href="mailto:jfernandes@mt.gov">jfernandes@mt.gov</a></td>
</tr>
<tr>
<td>Jill</td>
<td>Swenson</td>
<td>Sanford Health</td>
<td>Clinical Strategist</td>
<td><a href="mailto:jill.r.swenson@sanfordhealth.org">jill.r.swenson@sanfordhealth.org</a></td>
</tr>
<tr>
<td>First Name</td>
<td>Last Name</td>
<td>Organization</td>
<td>Job Title</td>
<td>Email</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Joe</td>
<td>Tabler</td>
<td>Kalispell Regional Medical Center</td>
<td>Clinical Pharmacist</td>
<td><a href="mailto:ctabler@krmc.org">ctabler@krmc.org</a></td>
</tr>
<tr>
<td>John</td>
<td>Bartkus</td>
<td>Pensivia</td>
<td>Principal Program Manager</td>
<td><a href="mailto:t-john.bartkus@heart.org">t-john.bartkus@heart.org</a></td>
</tr>
<tr>
<td>John</td>
<td>Clymer</td>
<td>National Forum for Heart Disease &amp; Stroke Prevention</td>
<td>Executive Director</td>
<td><a href="mailto:john.clymer@nationalforum.org">john.clymer@nationalforum.org</a></td>
</tr>
<tr>
<td>Julia</td>
<td>Schneider</td>
<td>National Association of Chronic Disease Directors (NACDD)</td>
<td>Co-Lead CVH Team</td>
<td><a href="mailto:jschneider@chronicdisease.org">jschneider@chronicdisease.org</a></td>
</tr>
<tr>
<td>Julie</td>
<td>Harvill</td>
<td>American Heart Association</td>
<td>Million Hearts® Operations Manager</td>
<td><a href="mailto:julie.harvill@heart.org">julie.harvill@heart.org</a></td>
</tr>
<tr>
<td>Kamesha</td>
<td>Ellis</td>
<td>Centers for Disease Control and Prevention (CDC)</td>
<td>Project Officer</td>
<td></td>
</tr>
<tr>
<td>Karen</td>
<td>Gray-Leach</td>
<td>SCL Health</td>
<td>Medical Home Coordinator/Educator RN</td>
<td><a href="mailto:kgray-leach@sclhealth.org">kgray-leach@sclhealth.org</a></td>
</tr>
<tr>
<td>Kari</td>
<td>Matthys</td>
<td>Sanford Health</td>
<td></td>
<td><a href="mailto:kmatthys@sanfordhealth.org">kmatthys@sanfordhealth.org</a></td>
</tr>
<tr>
<td>Katelin</td>
<td>Conway</td>
<td>Mountain-Pacific Quality Health (MPQHF)</td>
<td>Account Manager</td>
<td><a href="mailto:kconway@mpqhf.org">kconway@mpqhf.org</a></td>
</tr>
<tr>
<td>Kim</td>
<td>Pullman</td>
<td>Montana Department of Public Health and Human Services (MT DPHHS)</td>
<td>Wellness Program Manager</td>
<td><a href="mailto:kpullman@mt.gov">kpullman@mt.gov</a></td>
</tr>
<tr>
<td>Kristen</td>
<td>Range</td>
<td>Mountain-Pacific Quality Health (MPQHF)</td>
<td>Senior account manager</td>
<td><a href="mailto:kschuster@mpqhf.org">kschuster@mpqhf.org</a></td>
</tr>
<tr>
<td>Laura</td>
<td>King</td>
<td>American Heart Association</td>
<td>Director of Public Health</td>
<td><a href="mailto:laura.king@heart.org">laura.king@heart.org</a></td>
</tr>
<tr>
<td>Lauren</td>
<td>Owens</td>
<td>Centers for Disease Control and Prevention (CDC)</td>
<td>Public Health Analyst, Million Hearts®</td>
<td><a href="mailto:lwens@cdc.gov">lwens@cdc.gov</a></td>
</tr>
<tr>
<td>Laurence</td>
<td>Sperling</td>
<td>Centers for Disease Control and Prevention (CDC)</td>
<td>Executive Director, Million Hearts®</td>
<td><a href="mailto:lspertling@cdc.gov">lspertling@cdc.gov</a></td>
</tr>
<tr>
<td>Libby</td>
<td>Kyllo</td>
<td>Sanford Health</td>
<td>Community Health Worker</td>
<td><a href="mailto:libby.kyllo@sanfordhealth.org">libby.kyllo@sanfordhealth.org</a></td>
</tr>
<tr>
<td>Lisa</td>
<td>Jones Barker</td>
<td>American Heart Association</td>
<td>Senior Vice President, Health Strategies</td>
<td><a href="mailto:lisa.jones.barker@heart.org">lisa.jones.barker@heart.org</a></td>
</tr>
<tr>
<td>Marilyn</td>
<td>McLaury</td>
<td>Montana Department of Public Health and Human Services (MT DPHHS)</td>
<td>QI Coordinator</td>
<td><a href="mailto:mmclaury@mt.gov">mmclaury@mt.gov</a></td>
</tr>
<tr>
<td>Melissa</td>
<td>House</td>
<td>Montana Department of Public Health and Human Services (MT DPHHS)</td>
<td>Program Manager</td>
<td><a href="mailto:melissa.house@mt.gov">melissa.house@mt.gov</a></td>
</tr>
<tr>
<td>Mike</td>
<td>Lionbarger</td>
<td>Centers for Disease Control and Prevention (CDC)</td>
<td>Public Health Analyst</td>
<td><a href="mailto:mlionbarger@cdc.gov">mlionbarger@cdc.gov</a></td>
</tr>
<tr>
<td>First Name</td>
<td>Last Name</td>
<td>Organization</td>
<td>Job Title</td>
<td>Email</td>
</tr>
<tr>
<td>------------</td>
<td>----------------</td>
<td>--------------------------------------------------------</td>
<td>-----------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Mike</td>
<td>McNamara</td>
<td>Montana Department of Public Health and Human Services (MT DPHHS)</td>
<td>CV Specialist</td>
<td><a href="mailto:mmcnamara@mt.gov">mmcnamara@mt.gov</a></td>
</tr>
<tr>
<td>Patricia</td>
<td>Kosednar</td>
<td>Mountain-Pacific Quality Health (MPQHF)</td>
<td>Program Manager</td>
<td><a href="mailto:pkosednar@mpqhf.org">pkosednar@mpqhf.org</a></td>
</tr>
<tr>
<td>Rachael</td>
<td>Zins</td>
<td>University of Montana</td>
<td>Pharmacist</td>
<td><a href="mailto:rachael.zins@umontana.edu">rachael.zins@umontana.edu</a></td>
</tr>
<tr>
<td>Roberta</td>
<td>Wagner</td>
<td>Southern Peigan Health Center</td>
<td>Admin</td>
<td><a href="mailto:rwagner@blackfeetnation.com">rwagner@blackfeetnation.com</a></td>
</tr>
<tr>
<td>Sarah</td>
<td>Leake</td>
<td>Mountain-Pacific Quality Health (MPQHF)</td>
<td>Quality Improvement Management</td>
<td><a href="mailto:sleake@mpqhf.org">sleake@mpqhf.org</a></td>
</tr>
<tr>
<td>Sharon</td>
<td>Nelson</td>
<td>American Heart Association</td>
<td>Program Initiatives Manager</td>
<td><a href="mailto:sharon.nelson@heart.org">sharon.nelson@heart.org</a></td>
</tr>
<tr>
<td>Susan</td>
<td>Morgan</td>
<td>Northern Montana Health Care</td>
<td>Director of Clinic Nursing</td>
<td><a href="mailto:morgsus@nmhcare.org">morgsus@nmhcare.org</a></td>
</tr>
<tr>
<td>Trina</td>
<td>Filan</td>
<td>Montana Department of Public Health and Human Services (MT DPHHS)</td>
<td>Program Evaluator</td>
<td><a href="mailto:trina.filan@mt.gov">trina.filan@mt.gov</a></td>
</tr>
</tbody>
</table>
Welcome and Opening Remarks

JOHN CLYMER
Executive Director
National Forum for Heart Disease & Stroke Prevention

Objectives for Today
1. Identify strategies to increase patient engagement in managing hypertension and hypercholesterolemia
2. Increase awareness of Million Hearts® strategies and activities for 2020
3. Increase stakeholder awareness of the links between hypertension/hypercholesterolemia and co-morbidities such as diabetes and dementia
4. Develop strategies to increase community supports for patient management of hypertension and hypercholesterolemia

Advancing Million Hearts® - Montana Planning Committee

Member
Crystelle Fogle
MT DPHHS – Cardiovascular Health Program

Member Organization
MT Primary Care Association

Carl Tabler
Woodland Clinic

Amanda Cahill
American Heart Association

Courtney Buys
MT Primary Care Association

Susan Morgan
Northern Montana Family Medical Center

Karen Gray-Leach
St. Vincent Healthcare

Overview of the Day
SHARON NELSON, MPH
Program Initiatives Manager, Million Hearts® Collaboration
American Heart Association

What does Success Look Like?
• Welcome & Overview of the Day
• Engagement & Introductions
• Million Hearts® 2022 Update
• MT Hypertension Initiatives and Resources
• Managing Chronic Conditions in Changing Healthcare Environment
• Patient Engagement in Hypertension & Cholesterol Management
• Community Supports for Self-Management of Hypertension and Hypercholesterolemia

Engagement & Introductions
JOHN BARTKUS, PMP, CPF
Principal Program Manager
Pensivia

Event Facilitator

Engaging throughout the day on two platforms
Engaging throughout the day

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

Alignment and Connections

One of the sheets in your packet is “My Alignment Notes”

Opportunities I found to:
- Align with My Organization’s work
- Align with Others’ work

Alignment and Connections

Leverage your Partner Profiles which came from the organizational profile surveys

Introductions

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

Million Hearts® 2022 in Montana Executive Director Update

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

Disclaimer / Disclosure

The opinions expressed by the speaker do not necessarily reflect the opinions of the US Department of Health and Human Services, the Public Health Service, the Centers for Disease Control and Prevention, or the Center for Medicare and Medicaid Services.
Dr. Sperling has no conflicts to disclose.

Million Hearts® Executive Director Update

- Our hearts are focused on Millions across the Nation
- Cardiovascular Health and Prevention Remain a Priority
- Million Hearts® in Action
- Updates and Priorities
- Q & A (post your questions via Vevox)

Our world has changed since January 28, 2020

Impact of Pandemic on Cardiovascular Care (4/25/20)
- Our hearts are focused on Millions across the Nation
- Cardiovascular Health and Prevention Remain a Priority
- Million Hearts® in Action
- Updates and Priorities
- Q & A (post your questions via Vevox)
Million Hearts®
Executive Director Update

• Our hearts are focused on Millions across the Nation
• Cardiovascular Health and Prevention Remain a Priority
• Million Hearts® in Action
• Updates and Priorities
• Q & A (post your questions via Vexx)

Current Challenges / Concerns / Gaps in Care

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

Implications of Delay and Disruption of Care During the Pandemic

Recommendations for Patient Visits During Pandemic

• Don’t defer patient visits
• Use telehealth including telephone – if at all possible
• At each visit:
  o Ask about symptoms
  o Encourage EMS/911 for concerning symptoms
  o Remind them that it is safe
  o Ensure adequate medication refills and access
  o Inquire about physical activity and nutrition habits
  o Use the full care team to enhance patient care

COVID-19 & Cardiovascular Disease PSAs

Socioeconomic Status and Cardiovascular Outcomes: Challenges & Interventions

“In the midst of difficulty lies opportunity …”
Albert Einstein
Optimizing Opportunities

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

---

County-level Heart Disease Mortality Across Age Groups, 2017

- Our hearts are focused on Millions across the Nation
- Cardiovascular Health and Prevention Remain a Priority
- Million Hearts® in Action
- Updates and Priorities
- Q & A (post your questions via Vevox)

---

Relative Event Contributions to “the Million”

- Aspirin when appropriate reflects aspirin use for secondary prevention only; total does not equal sum of events prevented by risk factor type as those totals are not mutually exclusive; applies ratios obtained from PRISM and ModelHealth:CVD to estimate the number of events prevented during 2017-2021

---

Flu and Cardiovascular Disease

- Students have shown that flu is associated with an increase of heart attacks and stroke
- Flu vaccination is an AHA/ACC Class 1B Recommendation for Secondary Prevention for patients with cardiovascular disease
- Flu vaccinations have shown to reduce heart attacks by 15% to 40% in similar patient populations with hypertension and use of evidence-based therapies

---

MH® Updates

- CCC-F Campaign (R5A & beyond)
- Million Hearts TV Ad/As (Health: 138K events)
- Hypertension Control: Champions (116; 15M + 15K)
- Continuous Improvement: Think Tank
- AMA/AA Scientific Statement: SMMP
- CQIP & JAMA Cardiology invited commentaries
- CMS promotes V-BID in Final Payment Notice for 2021
- Reinvigorating 100 Congregations
- Updated Hypertension Control Change Package

---

MH® Priorities

- Strategic Planning given current realities – Impact Document
- Hypertension Control: Priority Populations (SG-CTA: Hypertension Roundtables)
- National/Association of Community Health Centers Hypertension Control
- Lipid Management: statin videos (1400 / 24M)
- Initiative focused on Nursing Partnerships (R56SE fellow)
- Increase uptake and implementation of evidence-based strategies
- Enhance existing interprofessional relationships and partnerships

---

Executive Director Update

- Million Hearts® will publicly recognize top-performing Million Hearts® Hospitals & Health Systems
- Applicants apply online by October 31, 2020 for the third quarter
- Million Hearts® will publicly recognize top-performing Million Hearts® Hospitals & Health Systems

---

Notes

- Aspirin when appropriate reflects aspirin use for secondary prevention only; total does not equal sum of events prevented by risk factor type as those totals are not mutually exclusive; applies ratios obtained from PRISM and ModelHealth:CVD to estimate the number of events prevented during 2017-2021

---
Influenza (Flu) Burden and Vaccination

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

Influenza (Flu) Burden and Vaccination

https://www.cdc.gov/flu/fluvaxview/coverage-1819estimates.htm
https://www.cdc.gov/flu/about/burden/preliminary-in-season-estimates.htm

Summary

Million Hearts® 2022: Executive Director Update

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

Million Hearts® Resources

- Hypertension Control Change Package, Second Edition
- Self-Measured Blood Pressure Monitoring
- Cholesterol Management
- Medication Adherence
- Cardiac Rehabilitation

Million Hearts® Resources

Million Hearts® 2022 Priorities

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

- Optimizing Care
  - Increase Use of Cardiac Rehab
  - Engage Patients in Heart-healthy Behaviors

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

Disclaimer / Disclosure

- Disclaimer:
  The opinions expressed by the speaker do not necessarily reflect the opinions of the US Department of Health and Human Services, the Public Health Service, the Centers for Disease Control and Prevention, or the Center for Medicare and Medicaid Services.

A Million Thanks!

More on Million Hearts at MillionHearts.hhs.gov
Reach me at LSperling@cdc.gov
Twitter @MillionHeartsUS

A Million Thanks!

Million Hearts® Hypertension Control Change Package

Lauren E. Owens, MPH
IHRC, Inc. Public Health Analyst
Million Hearts®/Stroke Prevention
Centers for Disease Control and Prevention
September 17, 2020

Million Hearts® Hypertension Control Change Package

The Model for Improvement

- Quality improvement goal(s)
- SMART objective(s)
- Plan-Do-Study-Act (PDSA) cycles
  - AKA “rapid tests of change”

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

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

Quality improvement goal(s)
- SMART objective(s)
- Plan-Do-Study-Act (PDSA) cycles
  - AKA “rapid tests of change”

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

Quality improvement goal(s)
- SMART objective(s)
- Plan-Do-Study-Act (PDSA) cycles
  - AKA “rapid tests of change”

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

Quality improvement goal(s)
- SMART objective(s)
- Plan-Do-Study-Act (PDSA) cycles
  - AKA “rapid tests of change”

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

- Includes 253 tools from 87 organizations
- Capitalizes on 7 years of MH Hypertension Control Champions
- Features more self-measured blood pressure monitoring (SMBP) resources
- Explores potentially undiagnosed hypertension
- Added new strategies that focus on chronic kidney disease (CKD) testing and identification
- Provides more patient supports for lifestyle modifications

Appendices – Additional Tools

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

What Can Public Health Do?

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

Getting to 70% Cardiac Rehabilitation Participation

Haley Stolp, MPH
IHRC, Inc. Public Health Analyst
Million Hearts®
Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention
September 17, 2020

Appendices – Additional Tools

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

Million Hearts® Cardiac Rehabilitation Collaborative Road Map

- Joining efforts to reach 70% CR participation by 2022
- Quarterly calls of reps from ~200 organizations
- CR professionals, health care team members, QI specialists, hospital and health system administrators, public health professionals, payers, and innovators
- Shared ‘action plan’ of objectives; report progress
  1. Increase awareness of the value of CR among health systems, clinicians, patients and families, employers, payers
  2. Increase use of best practices for referral, enrollment, and participation
  3. Build equity in CR referral, participation, and program staffing
  4. Increase sustainability, affordability, and accessibility through innovations in program design, delivery, and payment
  5. Measure, monitor, and report progress toward the CRC aim

Email millionheartsCRC@cdc.gov to join

CR Communications Toolkit

- Infographics, factsheets, hospital case studies
- Patient testimonials on cards and in YouTube videos
- Social media posts with #CRSavesLives and #CardiacRehabChat
- CR Million Hearts® web content that can be put on your webpage(s)
Million Hearts® / AACVPR
Cardiac Rehabilitation Change Package

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

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

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

Hybrid or Home-based Cardiac Rehabilitation


Olson, T. Balancing Technology with the Human Touch to Promote Exercise is Medicine. AACVPR 2018

Proposed Rule by CMS: Hospital Outpatient Prospective Payment

Opportunities to Build Equity in the Delivery of CR

• Automatic referral with care coordination (hint: TAKEheart)
• Offer culturally appropriate enabling services → leverage patient resources, patient ambassadors, and community assets
• Minimize obstacles for participation and reward participation → see strategies in the CR Change Package and/or send us your own
• Employ racially and ethnically diverse CR program staff
• Help eligible hospital employees participate in CR

Assessing Performance and Improving Outcomes

CR Capacity in the US

Hybrid or Home-based Cardiac Rehabilitation

Proposed Rule by CMS: Hospital Outpatient Prospective Payment

Opportunities to Build Equity in the Delivery of CR

Thank You!

Haley Strip, MPH
HStrip@cdc.gov

Contact the Million Hearts® CR Collaborative at millionheartscrc@cdc.gov for questions, comments, or feedback.
Q&A

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

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

Haley Stolp, MPH
IHRC, Inc. Public Health Analyst HStolp@cdc.gov

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

Ask Questions on vevox.app
ID: 101-600-725

Hypertension Status in Montana
Crystelle Fogle, MBA, MS, RD

Partners

67

Key BP Focus of Grants

Sample Project Outcomes

Poll Question

Is blood pressure improvement currently a high priority in your organization?
1. Yes
2. No

Barriers

Resources

68

69

65

66

64

70

71

72
Supporting Clinical System Changes for Hypertension Control

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

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

Our levels of work
- Quality, Outcomes, Research and Analytics (Get With The Guidelines) – Paula Hudson, Paula.Hudson@heart.org
- Community Impact/Quality Improvement, Ambulatory – Jessica Newmyer, Jessica.Newmyer@heart.org
- CPR – Mike Dietch, Mike.Dietch@heart.org
- Advocacy/Government Relations – Amanda Cahill, Amanda.Cahill@heart.org
- Youth Market – Anne Miller, Anne.W.Miller@heart.org
- Communications – Heather Wadia, Heather.Wadia@heart.org

How Does The Program Work?

1. Measure and assess blood pressure measurement tools and technology
2. Establish clinical guidelines and best practices for measuring blood pressure
3. Identify gaps and implement corrective actions
4. Monitor and report on blood pressure measurement performance

Target: BP Can Make A Difference

- The American Heart Association and the American Medical Association partnered to launch the Target: BP initiative to improve blood pressure control and reduce heart disease by urging medical practices to prioritize blood pressure.

Target: Blood Pressure (BP) Can Make A Difference

- Target: BP supports physicians and care teams by offering access to the latest research, tools, and resources to reach and sustain blood pressure goals in their patient populations.

Goals of the Program

- Reduce the burden of cardiovascular disease
- Improve patient outcomes
- Increase public awareness of blood pressure
- Enhance quality of care

Measuring Accurately

- Blood pressure measurement tools and technology are validated
- Establish clinical guidelines and best practices for measuring blood pressure
- Identify gaps and implement corrective actions
- Monitor and report on blood pressure measurement performance

Clinical System Change Examples

- When first blood pressure measurement is elevated or high, take a second confirmatory blood pressure.
- Ensure blood pressure measurement protocols are standardized and using American Heart Association/American Medical Association recommendations for patient positioning for accurate blood pressure control.
- Implement in hospitals a protocol to ensure that patients are measuring their blood pressure in accordance with guidelines.
- Positioning of patients should be a priority in every hospital, as blood pressure measurement is a critical component of patient care.

Ask Questions on vevox.app
ID: 101-600-725
Measuring Accurately

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

Acting Rapidly

- www.targetbp.org tools and downloads
- Live virtual trainings and recorded webinars for clinical teams on Acting Rapidly
- Training includes: overcoming therapeutic inertia, team-based care, improving BP control through policy, strategies for prevention and treatment of hypertension, etc.
- AHA Risk Calculator
- Consultation on resources and strategies from AHA Community Impact Team

Partnering with Patients and Community

- www.targetbp.org tools and downloads
- Video for patients teaching them how to take their SMBP measurement
- Example protocols for SMBP monitor loaner programs
- New CPT codes to cover SMBP
- Live virtual trainings and recorded webinars for clinical teams on Partnering with Patients and Community
- Implementation of standardized referral process to local QuitLine for smoking cessation support

2020 Montana Legislative Agenda

- Restrictions on Sales of Flavored Tobacco and Vape Products – State level request
- Stroke Systems of Care legislation (Requiring Data Collection) – State level request
- Fighting Preemption (protecting local governments and Boards of Health) – State level work
FOR MORE INFORMATION OR TO GET INVOLVED:

EMAIL AMANDA CAHILL, GOVERNMENT RELATIONS DIRECTOR
Amanda.cahill@heart.org
AND
SIGN UP FOR RELEVANT MONTANA ACTION ALERTS ON
YOURTHECURE.ORG!

YOUR VOICE IS CRUCIAL TO OUR WORK, THANK YOU!

Ask Questions on vevox.app
ID: 101-600-725

Montana Advancing Million Hearts®
Patty Kosednar
Virtual Workshop
September 17, 2020

Our Approach

Learning and action networks (LANs)
Regional approach
Align requirements, resources, efforts

Mission
A statewide/regional approach, leveraging the combined resources and expertise of participating members to prevent the development and progression of and improve outcomes for
– cardiovascular disease (CVD),
– diabetes (DM),
– chronic kidney disease (CKD),
– and related conditions.

Activities of LAN

1. Group education
2. Peer-to-peer sharing
3. Data collection/analytics
4. Identify needs and gaps in care and resources
5. Connect subject matter experts where needed
6. Identify topics, define scope and deliverables and recruit for working groups
7. Support topics, define scope and deliverables and recruit for activity packs
**LAN Events**

Chronic Disease/COVID-19

<table>
<thead>
<tr>
<th>August/September</th>
<th>Diabetes</th>
<th>Chronic Kidney Disease (CKD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td></td>
<td>(in progress)</td>
</tr>
</tbody>
</table>

Can still register

<table>
<thead>
<tr>
<th>October/November</th>
<th>Diabetes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>January/February</th>
<th>Chronic Kidney Disease (CKD)</th>
</tr>
</thead>
</table>

**Q&A**

Crystelle Fogle
Montana Dept of Public Health & Human Services

Jessica Newmyer
American Heart Association

Patty Kosednar
Mountain-PMQ's Quality Health

**Stretch Break**

2:00 mins

**Hypertension and Dementia**

JAMES RICHARDS, MD
Stroke Medical Director
St. Vincent Healthcare

**Vascular Dementia**

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

**Stroke and Dementia**

- Stroke increases risk of dementia
- Cognitive performance was inversely correlated with BP over 12-14 year period

- Framingham Heart Study
- BP control decreased risk later life cognitive decline

- Honolulu-Asia Aging Study
- BP control decreased risk later life cognitive decline

- EVA study
- Patients with controlled BP had some risk of cognitive decline as noncontrolled patients

**Control of BP and Dementia**

- Risk Factors
  - Age
  - Race: higher in AA
  - ApoE status e4: single copy 2x risk
  - TBI, CTE
  - Stroke

- Types
  - Alzheimer disease dementia (AD)
  - Vascular Dementia
  - Lewy Body Dementia
  - FTD Dementia

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

- Stroke and Dementia
  - Stroke increases risk of dementia
  - Only 60% VD
  - See increase in AD - ?effect of the stroke unmasking AD
  - Autopsy study
  - AD pathology and at least 1 lacunar stroke = 20 times risk of clinical dementia vs AD pathology and no stroke
  - Interaction between stroke and dementia risk, Hypertension – main stroke risk factor

- Control of BP and Dementia Risk?
  - Framingham Heart Study
  - Cognitive performance was inversely correlated with BP over 12-14 year period
  - Honolulu-Asia Aging Study
  - BP control decreased risk later life cognitive decline
  - EVA study
  - Patients with controlled BP had some risk of cognitive decline as noncontrolled patients

- Stroke and Dementia
  - Stroke increases risk of dementia
  - Cognitive performance was inversely correlated with BP over 12-14 year period
Control of BP and Dementia Risk

- SPRINT-MIND Study
  - Intensive BP control < 120 vs <140
  - Lower incidence of MCI but not dementia
  - Even the control arm had good BP control?

Both logic and most studies support better BP control with lower risk dementia.

Q&A

THANK YOU!

James Richards, MD
Stroke Medical Director
St. Vincent

Managing Chronic Conditions in a Changing Healthcare Environment

- LAURENCE SPERLING
  MD, FACC, FACI, FAHA, FSFC
  Executive Director
  Million Hearts®, CDC
- EDUARDO SANCHEZ
  MD, MPH
  Chief Medical Officer
  American Heart Association

Moderated by JAMES DEFOE, PHARMD
Clinical Pharmacist, PureView Health Center

Causes of Death: USA (2018)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Heart disease</td>
<td>655,381</td>
<td>23.1%</td>
</tr>
<tr>
<td>2</td>
<td>Cancer</td>
<td>599,274</td>
<td>21.1%</td>
</tr>
<tr>
<td>3</td>
<td>Accidents</td>
<td>167,127</td>
<td>5.9%</td>
</tr>
<tr>
<td>4</td>
<td>Chronic lower resp.</td>
<td>159,486</td>
<td>5.6%</td>
</tr>
<tr>
<td>5</td>
<td>Stroke</td>
<td>147,810</td>
<td>5.2%</td>
</tr>
<tr>
<td>6</td>
<td>Alzheimer’s disease</td>
<td>122,019</td>
<td>4.3%</td>
</tr>
<tr>
<td>7</td>
<td>Diabetes mellitus</td>
<td>84,946</td>
<td>3.0%</td>
</tr>
<tr>
<td>8</td>
<td>Influenza/pneumonia</td>
<td>59,120</td>
<td>2.1%</td>
</tr>
<tr>
<td>9</td>
<td>Kidney disease</td>
<td>51,386</td>
<td>1.8%</td>
</tr>
<tr>
<td>10</td>
<td>Intentional self harm</td>
<td>48,344</td>
<td>1.7%</td>
</tr>
</tbody>
</table>


AHA Mission Statement

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

Initial Insights

- Characteristics of and important lessons from the COVID-19 Outbreak in China
  - Case Fatality Rates (CFR) by age and underlying conditions
    - Age 80 or older: 14.8%
    - Age 70 – 79: 8.0%
    - Cardiovascular disease: 10.3%
    - Diabetes: 7.3%
    - Hypertension: 6.0%

Hypertension

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

Race/ethnicity Prevalence (HTN) Prevalence (Controlled)

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Prevalence</th>
<th>Prevalence Controlled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic Whites</td>
<td>46%</td>
<td>32%</td>
</tr>
<tr>
<td>Non-Hispanic Blacks</td>
<td>54%</td>
<td>25%</td>
</tr>
<tr>
<td>Non-Hispanic Asians</td>
<td>39%</td>
<td>19%</td>
</tr>
<tr>
<td>Hispanics</td>
<td>36%</td>
<td>25%</td>
</tr>
</tbody>
</table>

108 million (45%) of adults in US with hypertension ($≥130 \text{mm Hg}$) or taking blood pressure medications. cdc.gov; accessed 7/14/2020

Diabetes (2013 – 2016)

- 26.9 million adults with diagnosed diabetes
- 7.3 million with undiagnosed diabetes in US

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Prevalence</th>
<th>Diabetes Prevalence</th>
<th>Undiagnosed Disease Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic Whites</td>
<td>11.9%</td>
<td>10.9%</td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic Blacks</td>
<td>16.4%</td>
<td>14.5%</td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic Asians</td>
<td>14.9%</td>
<td>13.0%</td>
<td></td>
</tr>
<tr>
<td>Hispanics</td>
<td>14.7%</td>
<td>12.7%</td>
<td></td>
</tr>
</tbody>
</table>

Race/ethnicity Prevalence

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic Whites</td>
<td>42.2%</td>
</tr>
<tr>
<td>Non-Hispanic Blacks</td>
<td>49.6%</td>
</tr>
<tr>
<td>Non-Hispanic Asians</td>
<td>17.4%</td>
</tr>
<tr>
<td>Hispanics</td>
<td>44.8%</td>
</tr>
</tbody>
</table>

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

People of any age with certain underlying conditions are at increased risk of severe COVID-19

- Chronic kidney disease
- COPD
- Immunocompromised from solid organ transplant
- Obesity (BMI ≥ 30)
- Serious heart conditions (HF, CAD, cardiomyopathies)
- Stroke (recent or prior)
- Type 2 DM

COVID-19 Mortality

Compared to White people, the age-adjusted COVID-19 mortality rate for:

- Black people is 3.8 times as high
- American Indian/Alaska Native people is 3.2 times as high
- Pacific Islander people is 2.9 times as high
- Hispanic/Latino people is 2.5 times as high
- Asian people is 1.5 times as high.

Source: cdc.gov; accessed 7/14/2020

Socioeconomic factors that may contribute to disproportionality

- “Essential” work
- Crowded, substandard housing conditions
- Uninsurance - No Insurance
- Underinsurance
- Undocumented residents

Reckoning: Post-COVID Health and Healthcare System

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

PATIENT ENGAGEMENT IN HYPERTENSION AND CHOLESTEROL MANAGEMENT

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

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

Bozeman Health strives to improve community of health and quality of life by being your partner in health and wellness, compassionately delivering the best care for each person, every time.

RN-Pharmacist Hypertension Clinic

- The RN-Pharmacist Hypertension Clinic started in January 2019.
- The team consists of 8 RNs and Clinical Pharmacists.
- All practitioners have signed the compact agreement.
- Year to date, 240 patients have participated in the program.
- 82% of the patients are at goal within 9 weeks.
- After graduating, patients receive a follow-up phone call every 3 months for the first year.
- Continue to expand the program.

RN-Pharmacist HTN Clinic & Patient Engagement
Our innovative approach!

Celebrating our first birthday

Educational information

Blood pressure checks

Drawing for the Theme Basket

Angel food cake and strawberries

Sparkling Apple Cider

Stress Relieving Hearts

Motivational Interview

Patient Engagement

Patient Survey results: 4.8/5

- I'm so excited to be part of this
- This is the push I needed
- Lots of attention to detail in a cost-effective manner
- I like this program because we have more time to discuss issues
- I have a better general understanding and how to approach the future
In summary:

- Tools and Techniques Used to Improve Patient Engagement

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

DATA

- Hypertension
  - Among participants diagnosed with hypertension (79%)
  - 9.1% increase in individuals meeting blood pressure goals
  - EHR dashboard to measure and monitor patients with different diabetes/blood pressure meeting
  - 75% of patients with hypertension met blood pressure goals

- Lipid Panel
  - 62% of participants had pre and post enrollment lipid panel, which of those
  - 5.1% Reduction in LDL
  - 4.5% Reduction in Triglycerides
  - 4.0% Reduction in Cholesterol
  - No significant change noted in HDL

INTERVENTIONS

- Weekly Bridging Center clinics
  - Core team
  - RN
  - Assessments
  - POCT
  - Lipid panel, HgbA1C, Glucose
  - Education (verbal and written)
  - Referrals
    - Community Health Worker (CHW)
    - Social determinants of health
    - Referrals to community programs
  - Pharmacist
    - Pill box fills and education

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

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

*Take control of your health
*Learn self-management skills to live life to fullest
*Set your own goals and make a step-by-step plan to improve your health and life
INTERVENTIONS (continued)
• Assessing social determinants of health
  - employment
  - affordable housing
  - food security
  - transportation needs
  - stress
  - relationships
  - ADLs

INTERVENTIONS (continued)
• Community partnerships and collaboration
  - Walk for wellness
  - Partnerships with community facility that provided a free space to exercise
  - Cardiac ready community
  - Handouts and flyers made during heart month

TRANSITIONS
• Going from Grant funding to Operationalizing
  - CPC+ (Mayville)
  - Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that focuses on solving primary care’s core challenges through regionally based, multi-payor payment reform and care delivery transformation. Practices are redesigned and reorganized around patient-centered medical homes with support from federal, state, and local entities. A regional improvement network is established to facilitate learning and implementation. Practices will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health. ND was chosen to participate in the program starting in 2018. It is a 5 year program.

• CCM Billing (Webster)
  - In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for CCM services furnished to Medicare patients with multiple chronic conditions.

• Care management for chronic conditions including systematic assessment of the patient’s medical, functional, and psychosocial needs; systematic approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.

QUESTIONS?

REFERENCES

Lunch & Networking
Use Zoom Private Chat to Connect
Meeting Resumes at 12:50 pm

Kickstart to Resume

Afternoon Breakouts / Facilitated Discussions

Breakout Workgroups

Breakout Session Topics
- Strategies for Increasing Patient Engagement in managing chronic conditions
- Strategies for Increasing Community Support for managing chronic conditions

Workgroup Groups
- PE1, PE2
- CS1, CS2

Breakout Session Report Out
- Common Themes
- Common Themes

JEN CHILDRESS
Principal Program Manager
Pensivia

JOHN BARTKUS
Principal Program Manager
Pensivia
Workgroup Objectives

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

GROUP QUESTIONS - FOR YOUR TOPIC:
1. What are you doing now? What are the results? (~15 mins)
2. What did you learn today that might influence your direction or support you? (~10 mins)
3. How does patient engagement change as a result of Covid-19? (~10 mins)
4. What challenges/barriers do we have to overcome? (~10 mins)
5. How can we address those challenges? (~15 mins)

INDIVIDUAL TAKEAWAYS: (~5 mins)
- What new partners have I identified with whom I can work to further my/their goals?
- What two actions will I take based on what I learned today?

Workgroup Mechanics

Common Themes
Report Outs ~ 5 mins each

Breakout Session ~ 65 mins

2:05 pm
2:15 pm MT

PE1
Main Zoom Room
PE2
CS1
CS2

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

Breakouts In Progress

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

Common Themes and Report Outs

Order of Report Outs...

PE1
PE2
CS1
CS2

Order of Report outs...

PE1
PE2
CS1
CS2

Group Report Outs

Report Out Topics

Strategies for Increasing Patient Engagement in managing chronic conditions
Strategies for Increasing Community Support for managing chronic conditions

Group Reports start at 2:15 pm.

Order of Report Out Topics:

PE1
PE2
CS1
CS2

Advancing Million Hearts®

Aim to Save Lives, Improve Health, and Reduce Disparity

Partners Working Together in Montana Online Convening - Sep 17, 2020

Schedule

2:05 pm – Group Reports Begin
2:15 pm – Common Strategies/Themes
2:35 pm – Next Steps
2:45 pm – Final Comments/Adjourn

154 155 156

157 158 159

160 161

Next Steps

CRYSTELLE FOGLE, MBA, MS, RD
Program Manager
Program Manager, Million Hearts® Collaboration
American Heart Association

Adjourn

LAURA KING
Director of Public Health
American Heart Association

JULIE HARVILL, MPA, MPH
Operations Manager, Million Hearts® Collaboration
American Heart Association
### What tools, resources or best practices do you use?

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Trauma/health care</th>
<th>Self-measured blood pressure monitoring</th>
<th>Clinical decision support tools</th>
<th>Health care workers</th>
<th>Medication therapy management by pharmacists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allusion Health</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>American Heart Association</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Bozeman Health</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mercury Street Medical Group</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Montana Hospital Association (MHA)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mountain-Pacific Quality Health (MPQHF)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Montana Department of Public Health and Human Services (MT DPHHS)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>National Forum for Heart Disease &amp; Stroke Prevention</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Northern Montana Health Care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Northwest Physicians</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>PureView Health Center</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Sanford Health</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>SCI Health Medical Group-Billings/St. Vincent Medical Group</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Southern Pegan Health Center</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>St. Peter’s Health</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

### Degree to which you have found the following to be barriers to your work

<table>
<thead>
<tr>
<th>Barriers to Your Work</th>
<th>Org Survey Responses (x10 anonymous)</th>
<th>Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>3 3 2 2 3 3 3 5 4 3 3 3 3 5 4 3</td>
<td>3.2</td>
</tr>
<tr>
<td>Patient engagement</td>
<td>5 3 2 3 3 3 3 5 2 2 3 3 5 2 2</td>
<td>3.1</td>
</tr>
<tr>
<td>Staffing capacity</td>
<td>4 4 1 3 2 3 4 4 1 3 2 3 4 4 1</td>
<td>2.9</td>
</tr>
<tr>
<td>Physician engagement</td>
<td>3 3 2 4 4 1 2 3 1 2 2 3 1 2</td>
<td>2.5</td>
</tr>
<tr>
<td>Lack of management support</td>
<td>3 2 1 2 4 1 2 5 1 2 2 3 1 2</td>
<td>2.3</td>
</tr>
</tbody>
</table>

### Degree to which you have found the following to be barriers to implementing innovative approaches

<table>
<thead>
<tr>
<th>Barriers to Implementation</th>
<th>Org Survey Responses (x11 anonymous)</th>
<th>Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>4 3 3 3 3 3 3 5 5 2 4 3 3 3 3</td>
<td>3.5</td>
</tr>
<tr>
<td>Staffing capacity</td>
<td>4 3 4 3 3 3 3 2 4 1 3 3 3 2</td>
<td>3.0</td>
</tr>
<tr>
<td>Patient engagement</td>
<td>3 3 3 3 3 3 3 2 5 2 1 2 3 2</td>
<td>2.7</td>
</tr>
<tr>
<td>Physician engagement</td>
<td>2 3 3 3 3 4 4 1 1 5 1 1 2 5</td>
<td>2.5</td>
</tr>
<tr>
<td>Lack of management support</td>
<td>2 3 3 3 3 4 4 1 1 5 1 1 2 2</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Source: Pre-meeting questionnaire.
### Which of the following resources or best practices do you use?

<table>
<thead>
<tr>
<th>✓ Team-based care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-measured blood pressure monitoring</td>
</tr>
<tr>
<td>Collaborative practice agreements with pharmacists</td>
</tr>
<tr>
<td>✓ Self-management support and education</td>
</tr>
<tr>
<td>Clinical decision support systems</td>
</tr>
<tr>
<td>✓ Community health workers</td>
</tr>
<tr>
<td>Medication therapy management by pharmacists</td>
</tr>
</tbody>
</table>

### What type of additional support or resources do you need to execute these strategies and activities?

| Resources for education for staff |

*Source: Pre-meeting questionnaire. Respondent(s): Molly Wendland*
Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists

What outcomes have you observed from use of the resources or best practices (above)?

The American Heart Association supports the use of all of these tools, resources and best practices when supporting quality improvement efforts in clinical systems.

What type of additional support or resources do you need to execute these strategies and activities?

Continued collaboration with clinical systems in order to share the resources and tools that the AHA has to offer.

With which community resources/organizations are you currently working to help patients manage chronic care?

Many healthcare organizations/clinical systems throughout the nation, primary care associations, quality improvement organizations, non-profit community based organizations, faith organizations, etc.

With which community resources/organizations would you like to work to help patients manage chronic care?

Continue to expand our engagement with healthcare organizations/clinical systems throughout the nation, primary care associations, quality improvement organizations, non-profit community based organizations, faith organizations, etc.

Please describe any innovative approaches you use to engage patients in self-management.

The AHA has resources to educate patients on self-management including in written/video format, multiple languages as well as example protocols for clinical systems implementing self-management into workflow.

What are the outcomes of innovative approaches that you have used?

Clinics have been able to improve hypertension outcomes for their patient populations.

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

The AHA is working with clinical systems in incorporating self-management into telehealth during COVID-19.

How has COVID-19 changed the way your organization and/or partners provide self-management support?

Emphasis on self-management integration into telehealth.

Source: Pre-meeting questionnaire. Respondent(s): Jessica Newmyer.
Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists

What outcomes have you observed from use of the resources or best practices (above)?

**Successful management of hypertension. HTN patients with blood pressure at goal within 9-12 weeks**

What type of additional support or resources do you need to execute these strategies and activities?

**It would be ideal to have a dedicated compensated leader to maintain and grow the program**

With which community resources/organizations are you currently working to help patients manage chronic health conditions?

- HRDC, Love Inc, Gallatin County Mental Health, GallaVan, Gallatin City-County Public Health, Eagle Mount

With which community resources/organizations would you like to work to help patients manage chronic health conditions?

- Care Connect

Please describe any innovative approaches you use to engage patients in self-management.

**Face to face visits with motivational interviewing, patient friendly Cardiosmart informatics, celebrating success with graduation certificate and mug.**

What are the outcomes of innovative approaches that you have used?

**Patients reaching and maintaining goal within 9-12 weeks; 3-month follow up in the first year after graduation to assure BP goal is maintained.**

What other innovative approaches might you try to engage patients in self-management?

- At-home 24 hour blood pressure monitoring

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

**We stopped taking new patients during the peak. We continued to follow our established patients by telephone. We are now seeing patients via teledem and face to face.**

How has COVID-19 changed the way your organization and/or partners provide self-management support?

**Adopted the use of teledem for follow up visits.**

*Source: Pre-meeting questionnaire. Respondent(s): Angela Jennings*
Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists

What outcomes have you observed from use of the resources or best practices (above)?

| Small but steady improvement each year |

What type of additional support or resources do you need to execute these strategies and activities?

| Our existing EHR requires a manual process to track HTN. |

Please describe any innovative approaches you use to engage patients in self-management.

| We have one care management RN that coordinates referrals to Behavioral Health, Comprehensive Medication Management, Diabetic Education, etc. based on needs. |

What are the outcomes of innovative approaches that you have used?

| We just started this approach and look forward to seeing the results. |

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

| We are providing more care via telehealth and telephone so some of our visits lack personal interaction. We are transitioning back to in clinic visits when necessary or desired. |

How has COVID-19 changed the way your organization and/or partners provide self-management support?

| Other than reduced in-clinic appointments and home visits, it really hasn’t changed the way we provide self management support. |

Source: Pre-meeting questionnaire.  Respondent(s): Barb Cook
**Which of the following resources or best practices do you use?**

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists

**With which community resources/organizations are you currently working to help patients manage chronic**

| MHA is partnering with the QIO, DPHHS, and MPCA on projects including antibiotic stewardship and opioid abuse; we are of course also partnering with DPHHS around telestroke interventions! |

**With which community resources/organizations would you like to work to help patients manage chronic**

| We are open to any partnerships and strategies that can improve patient health. |

**Please describe any innovative approaches you use to engage patients in self-management.**

| We have worked on Community Health Worker projects in the past; the HIIN project includes a patient-family engagement focus. |

**What are the outcomes of innovative approaches that you have used?**

| The CHW program showed significant reductions in readmissions and decrease in costs, in addition to improved health. The HIIN work has resulted in better hospital-based outcomes. |

*Source: Pre-meeting questionnaire. Respondent(s): Victoria Cech*
Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists

What outcomes have you observed from use of the resources or best practices (above)?

Streamlined and consistent workflows, data and protocols have been implemented, focus on high risk patients have reduced overall costs

Source: Pre-meeting questionnaire. Respondent(s): Patricia Kosednar
Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists

What outcomes have you observed from use of the resources or best practices (above)?

*Increased pharmacist engagement and clinics implementing clinical decision support systems to increase access to screening and care management services. Utilization of these tools has led to better patient management and increased access to programs. The CMS blood pressure measure appears to be improving in clinics and other facilities we have been working with. In the Undiagnosed Hypertension project, we saw more patients with their most recent (at least 2) blood pressure measures being diagnosed with hypertension after clinics reassessed the patients’ blood pressure status.*

What type of additional support or resources do you need to execute these strategies and activities?

*Expanded network of community health workers, more flexibility in electronic health records, and increased provider engagement. Additional information on what others are doing and what is working.*

With which community resources/organizations are you currently working to help patients manage chronic conditions?

*Mountain-Pacific Quality Health, University of Montana Skaggs School of Pharmacy, local health departments, health systems with DPP and DSMES programs, Community Integrated Health sites, community pharmacies, Community Health Centers, American Indian tobacco prevention specialists*

With which community resources/organizations would you like to work to help patients manage chronic conditions?

*WIC, local food banks, optometrists, dentists, more tribal governments and community health workers/navigators. In general, we need more community resources for chronic disease management.*

Please describe any innovative approaches you use to engage patients in self-management.

*CONNECT bi-directional referral system, expanding Community Integrated Health (community paramedicine), cardiovascular/diabetes GIS Hubs, home-based cardiac rehabilitation, digital health/online platforms, patient incentives/support, increased promotion and marketing, providing services in alternative locations, Offering funding to implement innovative approaches, expanding IPHARM, offering Discovery & Action Dialogues that may include patients. Pharmacist-led blood pressure management programs*

What are the outcomes of innovative approaches that you have used?

*Increased participation, slow movement in getting adaptation/implementation of these strategies. Some of the outcomes from #12 have led to being able to reach patients "where they are" like at community events and in their home.*

What other innovative approaches might you try to engage patients in self-management?

*We hope to partner with clinics and food pantries on a Food Farmacy project to improve access to healthier foods for patients with hypertension or high cholesterol. Montana also is working on a health information exchange.*

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

*Increased the move toward delivering services via telehealth methods to allow for continued program involvement by patients. Participation and some programs have declined or were put on hold, but educators and coaches have increased efforts to touch base with participants to ensure they are still engaged at some level. Partners have shifted many activities to online or telehealth. Looking at more online apps to increase contacts with patients when in-person isn’t feasible. DPHHS staff is able to telework. We have more online meetings and are using technology to keep grant projects moving forward.*

How has COVID-19 changed the way your organization and/or partners provide self-management support?

*DPHHS and health partners are encouraging patients to not avoid or delay care. There has been an accelerated shift toward telehealth services, and the Diabetes Program is looking into additional telehealth/online service platforms.*

Source: Pre-meeting questionnaire. Respondent(s): Crystelle Fogle/Marilyn McLaury/Carrie Oser/Melissa House/Jessie Fernandes/Mike McNamara/Kim Pullman
Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists

With which community resources/organizations are you currently working to help patients manage chronic:

*The National Forum for Heart Disease & Stroke Prevention brings together the most dynamic and diverse organizations in cardiovascular health to: Share successful strategies and practices, and lessons learned; Discuss new ideas in a collaborative environment; Develop, pilot and scale innovative approaches to prevent cardiovascular disease; Members value the opportunities created by the National Forum for them to engage in discussions that are uniquely inclusive, transparent and consensus-building. National Forum initiatives enable members to work together, across sectors, to develop and advance strategies to prevent heart disease and stroke in all populations; The National Forum’s Annual Meeting convenes 100 thought leaders from over 60 public, private and nonprofit organizations including our members and partners. During this time, our Annual Business Meeting of the organization is held where the National Forum Awards are presented. All Advancing Million Hearts participants are invited to register to attend our virtual annual meeting on October 15, 2020. Visit www.nationalforum.org*

Source: Pre-meeting questionnaire. Respondent(s): Julie Harvill
Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists

What outcomes have you observed from use of the resources or best practices (above)?

*Increased BP control with use of SMBP*

What type of additional support or resources do you need to execute these strategies and activities?

*More evidence based data to promote buy-in from providers*

With which community resources/organizations are you currently working to help patients manage chronic DPPHS TargetBP

With which community resources/organizations would you like to work to help patients manage chronic Advancing Million Hearts DPPHS TargetBP

Please describe any innovative approaches you use to engage patients in self-management.

*Work in progress*

What are the outcomes of innovative approaches that you have used?

*Greater interest*

What other innovative approaches might you try to engage patients in self-management?

*We would like to provide hypertension programs, engage facilities provide physical activity opportunities*

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

*More long distance engagement.*

How has COVID-19 changed the way your organization and/or partners provide self-management support?

*Increased use of telehealth*

Source: Pre-meeting questionnaire. Respondent(s): Susan Morgan
Which of the following resources or best practices do you use?

- ✓ Team-based care
- ✓ Self-measured blood pressure monitoring
- ✓ Collaborative practice agreements with pharmacists
- ✓ Self-management support and education
- ✓ Clinical decision support systems
- ✓ Community health workers
- ✓ Medication therapy management by pharmacists

What outcomes have you observed from use of the resources or best practices (above)?

Improvements in health & decrease in symptoms

What type of additional support or resources do you need to execute these strategies and activities?

Grant projects, cpc+

With which community resources/organizations are you currently working to help patients manage chronic

Behavioral Health, Pharmacy, Specialty Providers

With which community resources/organizations would you like to work to help patients manage chronic

Any available options

Please describe any innovative approaches you use to engage patients in self-management.

Clinical Health Coaching self-management action plans with patient specific smart goals

What are the outcomes of innovative approaches that you have used?

Improvement in ecqm data over 4 years

What other innovative approaches might you try to engage patients in self-management?

Group visits

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

Increased our phone and telehealth visits. Decreased access to care. Increased Behavioral Health needs

How has COVID-19 changed the way your organization and/or partners provide self-management support?

Increased use of telehealth, portal messaging communication, and phone interaction

Source: Pre-meeting questionnaire. Respondent(s): Cynthia Armstrong, RN,CHC
### Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists

### With which community resources/organizations are you currently working to help patients manage chronic

- **AWARE, PACT, Inch By Inch, Farmers to Families**

### With which community resources/organizations would you like to work to help patients manage chronic

- **Helena Food Share, Meals on Wheels, Living Life Well – Arthritis Foundation. Open to suggestions.**

*Source: Pre-meeting questionnaire. Respondent(s): James DeFoe*
### Which of the following resources or best practices do you use?

- ✔ Team-based care
- ✔ Self-measured blood pressure monitoring
- ✔ Collaborative practice agreements with pharmacists
- ✔ Self-management support and education
- ✔ Clinical decision support systems
- ✔ Community health workers
- ✔ Medication therapy management by pharmacists

### What outcomes have you observed from use of the resources or best practices (above)?

- Increased number of patients meeting BP and Hba1c goals; increased patient confidence in self-managing chronic conditions; increased completion of Advanced Care Plans

### What type of additional support or resources do you need to execute these strategies and activities?

- Additional funding for staffing, marketing, etc. Local resources such as transportation, volunteers and increased access to healthy food options

### With which community resources/organizations are you currently working to help patients manage chronic?

- Stanford University Self-Management Resource Center (facilitating self-management workshops)
- Valley Senior Services (senior center collaboration)
- Steele & Traill County Public Health
- Sanford Health Home Health Department

### With which community resources/organizations would you like to work to help patients manage chronic?

- Great Plains Food Bank

### Please describe any innovative approaches you use to engage patients in self-management.

- Starting to leverage Digital Platforms to meet patients at their level of readiness to change, starting with their goals. Utilize Lutheran Social Services (volunteer companions) to increase involvement and engagement of older adults.

### What are the outcomes of innovative approaches that you have used?

- Great feedback from patients, increased attendance to appointments and completion of action plans

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

- Similar to all health care systems, patients are starting to come back to the clinics and engage in their health. Increased screenings, more 1 on 1 appointments, increased education about self-care.

### How has COVID-19 changed the way your organization and/or partners provide self-management support?

- Using digital platforms, virtual workshops and telephone encounters for education

---

Source: Pre-meeting questionnaire. Respondent(s): Jill Swenson, Libby Kyllo
## Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists

### What outcomes have you observed from use of the resources or best practices (above)?

Hypertension with BP control is the most difficult for providers to get a grip on. There is no funding to purchase home BP cuffs to loan to patients.

### What type of additional support or resources do you need to execute these strategies and activities?

More health coaching, more Community Health Workers. More peer to peer encouraging by providers. Leadership

### With which community resources/organizations are you currently working to help patients manage chronic

YMCA--Diabetes and Heart Disease Prevention Program

### With which community resources/organizations would you like to work to help patients manage chronic

I would like to see ALL the healthcare facilities in our community and rural areas to come together to address it.

### Please describe any innovative approaches you use to engage patients in self-management.


### What are the outcomes of innovative approaches that you have used?

Not much change. Approaches are not widely utilized.

### What other innovative approaches might you try to engage patients in self-management?

Would love to offer virtual classes around self management of BP.

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

Patients are staying away from the clinics but increasing virtual visits.

### How has COVID-19 changed the way your organization and/or partners provide self-management support?

Reassignment and cut back hours of the Community Health Workers. Care Coordinators were reassigned to the COVID-19 Triage Line for Feb-April 2020. Overall reduction of resources available to provide patient support.

Source: Pre-meeting questionnaire. Respondent(s): Karen Gray-Leach, RN
Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists

What outcomes have you observed from use of the resources or best practices (above)?

- We've had positive outcomes

What type of additional support or resources do you need to execute these strategies and activities?

- Additional education, case management

With which community resources/organizations are you currently working to help patients manage chronic health conditions?

- Blackfeet Tribal Health

With which community resources/organizations would you like to work to help patients manage chronic health conditions?

- Community health nurses

Please describe any innovative approaches you use to engage patients in self-management.

- At-home logs, education for patient and family

What are the outcomes of innovative approaches that you have used?

- Improved HTN numbers

What other innovative approaches might you try to engage patients in self-management?

- We will try everything and anything to be innovative, we can work on this as a group

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

- Slowed down approach to patient engagement, closed clinic, no providers at times.

How has COVID-19 changed the way your organization and/or partners provide self-management support?

- Slowed down, patients were not able to come into the clinic

Source: Pre-meeting questionnaire. Respondent(s): Roberta Wagner
St. Peter's Health
Federally Qualified Health Center (FQHC); Health Care System

Which of the following resources or best practices do you use?

| ✓ Team-based care   |
| ✓ Self-measured blood pressure monitoring |
| ✓ Collaborative practice agreements with pharmacists |
| ✓ Self-management support and education |
| Clinical decision support systems |
| Community health workers |
| ✓ Medication therapy management by pharmacists |

What outcomes have you observed from use of the resources or best practices (above)?

*Increased patient engagement. Increased medication adherence. Increased provider and patient satisfaction.*

What type of additional support or resources do you need to execute these strategies and activities?

*EHR with clinical decision support—we will be upgrading our EHR over the next couple of years. Examples of successful community health worker programs and resources for implementing such programs within comparable health systems and/or populations*

With which community resources/organizations are you currently working to help patients manage chronic conditions?

*Diabetes Prevention Program (“Inch by Inch”), Living Life Well Program through RMDC, Walking With Ease through Lewis and Clark Public Health, Our Freedom From Smoking Program, Arthritis Exercise*

With which community resources/organizations would you like to work to help patients manage chronic conditions?

*Health Coaches for Hypertension Control (we are working on bringing this to our organization)*

Please describe any innovative approaches you use to engage patients in self-management.

*Incorporating new team members to increase ability to provide wrap around services and support: Community Paramedics and Registered Dietitians in the Clinic.*

What are the outcomes of innovative approaches that you have used?

*Both of those previously mentioned are new and lack robust outcome information at this point.*

What other innovative approaches might you try to engage patients in self-management?

*Community Health Workers further down the road*

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

*It has increased the incidence of outreach and support via phone or virtual visit.*

How has COVID-19 changed the way your organization and/or partners provide self-management support?

*It has provided us with the opportunity to quickly stand up a Community Paramedicine Program to increase patient engagement*

Source: Pre-meeting questionnaire. Respondent(s): Haylie Wisemiller