Welcome and Opening Remarks

LAURA KING
Director of Public Health
American Heart Association

Objectives for Today

- Increase awareness of Million Hearts® strategies and activities for 2020 (so you are aware of additional tools and resources to support this effort)
- Develop strategies for increasing patient engagement and activation in hypertension self-management
- Identify opportunities to collaborate with community partners to address patients’ social and economic needs (to enable them to better manage their health conditions)
- Develop strategies to maximize patient visits to support hypertension management

Overview of the Day

JULIE HARVILL
Operations Manager, Million Hearts® Collaboration
American Heart Association

Agenda

- Welcome & Overview of the Day
- Engagement & Introductions
- Million Hearts® 2020 Update
- SC Hypertension Initiatives and Resources
- Patient Engagement in Hypertension Self-Management
- Collaborating with Community Partners to Address Patients’ Social and Economic Needs
- Integrating Community Health Workers into Team-based Care
- Lunch (and networking through Zoom private chat)
- Breakout Sessions
- Group Report Outs
- Common Themes and Strategies
- Next Steps
- Wrap up / Adjourn @ 3:00pm

What does Success Look Like?

JOHN BARTKUS
Principal Program Manager
Pensivia

Engagement & Introductions

John Bartzus
Principal Program Manager
Event Facilitator

Engaging throughout the day

- Introduction to Million Hearts®
- Overview of Million Hearts® in South Carolina
- Collaborative efforts to address hypertension
- Patient engagement strategies
- Community partnerships
- Self-management tools
- Integrating community health workers
- Next steps
- Questions and discussion
Engaging throughout the day

Join at vevox.app
Or search Vevox in the app store
ID: 136-377-847

Where are you joining from today?

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 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

Our world has changed since January 28, 2020

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 Centers for Medicare and Medicaid Services.

Dr. Sperling has no conflicts to disclose.

Disclaimer/Disclosure

• Our hearts are focused on Millions across the Nation
• Cardiovascular Health and Prevention Remain a Priority
• Million Hearts® in Action
• Updates and Priorities
• Discussion / Q & A- following update on HCCP

Million Hearts® Executive Director Update
Impact of Pandemic on Cardiovascular Care

- Our hearts are focused on Millions across the Nation
- Cardiovascular Health and Prevention Remain a Priority
- Million Hearts® in Action
- Updates and Priorities
- Discussion / Q & A

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

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

Recommendations for Patient Visits During Pandemic

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

Socioeconomic Status and Cardiovascular Outcomes: Challenges & Interventions

“In the midst of difficulty lies opportunity…”

Albert Einstein
Optimizing Opportunities

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

Million Hearts® Executives Update

- Our hearts are focused on Millions across the Nation
- Cardiovascular Health and Prevention Remain a Priority
- Million Hearts® in Action
  - Updates and Priorities
  - Discussion / Q & A - following update on HCCP

Million Hearts® 2022 Aim:
Prevent a Million Heart Attacks and Strokes in Five Years

Relative Event Contributions to “the Million”

Flu and Cardiovascular Disease

- Studies have shown that flu is associated with an increase in heart attacks and strokes
- Flu vaccination is an AHA/ACC Class 1B Recommendation for Secondary Prevention for patients with cardiovascular disease
- Flu vaccinations have shown to prevent heart attacks by 80% to 90% and reduction risk reduction in myocardial infarction

Influenza (Flu) Burden and Vaccination

- Only 40% of adults Americans received flu vaccination during 2019
- There is a significant association between cardiovascular disease and vaccination
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

- 2020 American Heart Month: We’ve got this!
- Self-Measured Blood Pressure Monitoring
- Medication Adherence
- Cardiac Rehabilitation
- Healthy Is Strong
- Hypertension Control

A Million Thanks!

More on MillionHearts at Millionhearts.hhs.gov
Reach me at LSpertling@cdc.gov
Twitter @MillionHeartsUS

A Million Thanks!

Million Hearts® Resources

- Hypertension Control
- Change Package
- Lauren E. Owens, MPH
- IHRC, Inc. Public Health Analyst
- Million Hearts®
- Division for Heart Disease and Stroke Prevention
- Centers for Disease Control and Prevention
- September 1, 2020

More on MillionHearts at Millionhearts.hhs.gov
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The Model for Improvement

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

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

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

Hypertension Control Change Package (HCCP)

- 2nd Edition, 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

HCCP 2020

- Includes 253 tools from 87 organizations
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Use Practice Data to Drive Improvement

Determine HTN control and related process metrics for the practice. Regularly provide a dashboard with BP goals, metrics, and performance.

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
  • #MillionHeartsQI
• Speak with partners about how they can do the same

Q&A

Laurence Sperling, MD, FACC, FACP, FAHA, FASPC
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Lauren E. Owens, MPH
IHRC, Inc. Public Health Analyst, Million Hearts®
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Division for Heart Disease and Stroke Prevention, CDC

South Carolina Hypertension Initiatives and Resources

Katherine Plunkett
Sr Manager
South Carolina Primary Health Care Association

Vonda Evans
Community Impact Director
American Heart Association

La'Shanda Wood
Health Systems Specialist
South Carolina Dept of Health & Environmental Control

South Carolina Primary Health Care Association
Access to Quality Health Care, for all of South Carolina

Katherine Plunkett, LMSW, MPH
Senior Manager of Clinical Quality Improvement
South Carolina Primary Health Care Association
“Access to quality health care for all”

- SCPHCA TRAINING AND TECHNICAL ASSISTANCE INFRASTRUCTURE
  - Clinical Networks
  - Technical Assistance
  - Annual Clinical Network Retreat
  - SCPHCA First Thursday CQI Webinar Series

- CLINICAL QUALITY INITIATIVES
  - Chronic Disease Management
  - Care Coordination with the Medical Neighborhood

1. **UDS Uncontrolled Diabetes Rates**
   - Average annual diabetes control rates (Hba1c) for all patients 18-85yr with diabetes who had a hemoglobin A1c greater than 9%

2. **UDS Hypertension Control Rates**
   - Percentage of blood pressure adequately controlled at less than 140/90 mm HG

3. **UDS Adult Weight Screening & Follow-up Rates**
   - Percentage of patients 18+ yrs who had BMI outside normal range measured and follow-up plan documented.

4. **UDS Weight Assessment & Counseling for Children and Youth Rates**
   - State and national average for children and youth rates.

5. **UDS Adult Weight Assessment & Counseling Rates**
   - State and national average for adult weight assessment and counseling rates.

6. **UDS Hypertension Control Rates**
   - Percentage of hypertensive patients 18-85yr with blood pressure adequately controlled at less than 140/90 mm HG

7. **UDS Uncontrolled Diabetes Rates**
   - Average annual diabetes control rates (Hba1c) for all patients 18-85yr with diabetes who had a hemoglobin A1c greater than 9%

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   - Percentage of blood pressure adequately controlled at less than 140/90 mm HG

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   - Percentage of patients 18+ yrs who had BMI outside normal range measured and follow-up plan documented.

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    - State and national average for children and youth rates.

11. **UDS Adult Weight Assessment & Counseling Rates**
    - State and national average for adult weight assessment and counseling rates.

**Our MISSION STATEMENT**

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

**AHA TOOLS TO IMPROVE QUALITY OF CHRONIC DISEASE MANAGEMENT**

Advancing Million Hearts

Vonda Evans, Community Impact Director

**MULTIPLE CHRONIC CONDITIONS (MCC)**

- 1 in 4 Americans have 2+ concurrent chronic conditions including hypertension, diabetes, and heart disease.
- As the number of chronic conditions increases, the risks of the following outcomes also increase:
  - Mortality
  - Poor functional status; unnecessary hospitalizations
  - Adverse drug events; duplicative tests; conflicting medical advice.

- 66% of total health care spending is directed toward care for the approximately 27% of Americans with MCC.

- Individuals with MCC face financial challenges related to:
  - Out-of-pocket costs of care, including:
    - Higher out-of-pocket prescription drug costs and total out-of-pocket health care costs

**THE RESULTING EFFORTS**

**TARGET BP**

- Provides clinical guidelines to providers
- Offers face-to-face support to both providers and patients
- Connects clinical partners to others around the country engaged in the same work
- Offers recognition opportunities for any health care provider that demonstrates a commitment to, and/or achieves, clinical excellence.
Factors impacting blood pressure control

**Patient factors**
- Non-adherence to treatment
- Lifestyle / Habits
- Lack of support for patients to self-manage HTN
- Social Determinants of Health

**Physician factors**
- Competing priorities / time
- Guideline confusion / complexity
- Don’t use evidence-based treatment protocol
- Diagnostic Inertia
- Therapeutic Inertia

**System factors**
- Inaccurate Blood Pressure (BP) Measurements
  - Lack of standardized measurement protocols, competency testing and retraining
  - Creates uncertainty about reliability of BP
- Not an organizational priority / lack of buy-in

Clinical Inertia


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THE M.A.P. FRAMEWORK

**TARGET: BP RESOURCES ON MEASURING ACCURATELY**
- Technique quick checks
- Positioning materials and quiz
- Webinars and case studies
- Resources to support home-monitoring

TARGET: BP RESOURCES ON MEASURING ACCURATELY

SMBP helps patients and providers
- SMBP monitoring helps patients better self-manage their high blood pressure and allows providers to diagnose and manage hypertension more effectively

https://targetbp.org/tools_downloads/

Available resources:
- Training video*
- Infographic*
- SMBP recording logs
- General overview materials for patients
  - Available in English and Spanish


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ADDRESSING CHOLESTEROL

**RESOURCES WITHIN CCCC**
- Tools for patients
- Tools for providers
- Guidance on ASCVD Risk Calculator
- Continuing Education Opportunities
- Newsletter
- Podcast Series

ADDRESSING DIABETES

**SAMPLING OF PROGRAM MATERIALS**
www.knowdiabetesbyheart.org

Health Care Professional Tools and Resources
- Guidelines pocket guide
- ASCVD calculator
- Podcast series
- Webinar series
- AHA and ADA scientific statements and guidelines
- Professional decks

Patient Education Materials (English and Spanish)
- Patient educational resources
- Discussion guides on monthly email series
- Monthly "Ask the Experts" events
- ADA's "Living With Type 2" program

Implements programs and activities to help health systems apply and practice the most up-to-date, evidence-based treatment guidelines for primary and secondary prevention of CVD and stroke events in patients with type 2 diabetes.
What percent of South Carolina adults have high blood pressure?

1. 55.6%
2. 38.1%
3. 25.3%
4. 66.2%
### Hypertension

#### Prevalence of Hypertension, by Sex

<table>
<thead>
<tr>
<th></th>
<th>South Carolina</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>38.1%</td>
<td>40.2%</td>
</tr>
<tr>
<td>Female</td>
<td>32.3%</td>
<td>33.9%</td>
</tr>
</tbody>
</table>

#### Prevalence of Hypertension, by Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>South Carolina</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>8.1%</td>
<td>13.4%</td>
</tr>
<tr>
<td>24-34</td>
<td>14.0%</td>
<td>20.6%</td>
</tr>
<tr>
<td>35-44</td>
<td>26.0%</td>
<td>31.9%</td>
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<tr>
<td>45-54</td>
<td>40.7%</td>
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<tr>
<td>55-64</td>
<td>54.9%</td>
<td>60.9%</td>
</tr>
<tr>
<td>65+</td>
<td>66.5%</td>
<td>67.5%</td>
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</tbody>
</table>

### Hypertension Prevention and Management in South Carolina

- **Health Systems Interventions**
  - Systems level approach
  - Policy development
  - Integration of pharmacists into primary care settings utilizing the hybrid model of care to promote Medication Therapy Management

- **Community-Clinical Linkages**
  - We utilize community-clinical linkages to prevent and manage hypertension by developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live.
Provider Engagement
• Successfully engaging providers and their staff can have a dramatic impact on the patient provider health experience
• Involved providers lead to improved clinical outcomes

Collaborative Partners

Partners in Hypertension Prevention and Management
• South Carolina Pharmacy Association (SCPhA)
• South Carolina Primary Healthcare Association (SCPHCA)
• South Carolina Office of Rural Health (SCORH)
• The American Society of Hypertension
• The American Heart Association (Advancing Million Hearts)
• South Carolina Alliance of YMCAs

Disclosures
• Member of NHLBI Risk Assessment Workgroup
• Member of 2014 Hypertension Guidelines (JNC 8)
• Member of Evidence Rating Committee for ACC/AHA Hypertension Guidelines
• No financial disclosures

IMPACT: PREVALENCE OF HYPERTENSION – 2017 ACC/AHA AND JNC7 GUIDELINES
Use of validated HBPM devices to confirm the diagnosis of hypertension and to titrate antihypertensive medication in conjunction with telehealth counseling or clinical interventions. 

- Using a combination of office and out-of-office BP measurements, several useful BP patterns can be discerned.
- Data indicate that masked hypertension and masked uncontrolled hypertension are associated with high risk of CVD and mortality.
- Likewise, telehealth can be employed with valid out-of-clinic BP measurements, several useful BP patterns can be discerned.

Conduct an initial clinician competency exam for pertinent staff and new providers. Patient training provided by healthcare staff or civil health practitioners should lead the clinical support piece of SMBP interventions.

Prefered devices and cuffs

- Use an upper-arm cuff oscillometric device that has been validated
- Use a device that is able to automatically store all readings
- Use a device that can print results or can send BP values electronically to the healthcare provider
- Use a cuff that is appropriately sized for the patient's arm circumference

Preferred devices and cuffs

- Use a cuff that is appropriately sized for the patient's arm circumference
- Position Sit with back supported and both feet flat on the floor
- Have an empty bladder
- Do not talk or text
- Measurement without talking

Best practices for the patient preparation

Actions to Prepare Care Teams to Support SMBP

- Conduct training of clinicians to take blood pressure readings and teach SMBP techniques to their patients.
- Conduct in-clinic clinician competency exam for pertinent staff and new employees to demonstrate proper technique in:
  - Cuff selection
  - Patient positioning
  - Measurement without talking
  - Accurate observation of the blood pressure level
- Conduct additional competency training for all employees at regular intervals.

Actions to Prepare Care Teams to Support SMBP

- Train relevant team members (e.g., RNs, nurses, pharmacists) to lead the clinical support piece of SMBP interventions.
- Clinical support programs should be delivered only by clinicians specifically trained for the intervention.
- Incorporate this clinical support into existing disease management programs.

Actions to Empower Patients to Use SMBP

- Discuss with your patients:
  - Reasons for using SMBP devices
  - How to use the device
  - How to use the device
  - How to use the device
  - How to use the device
  - How to use the device

- When to measure BP (time of day/meal)
- What to measure BP
- What to measure BP
- What to measure BP
- What to measure BP
Home Blood Pressure Monitors

Conclusions
- Self-Monitored Blood Pressure and Home Blood Pressure Monitoring are critical components of team-based hypertension management.
- The SMBP and HBP values must be valid and trusted by the Team in order to have impact.

Q&A

Collaborating with Community Partners to Address Patients Social and Economic Needs

We Have the Resources

The Vision: Dedicated Partners for Community Health
**Maximizing Patient Visits to Support Hypertension Management**

**CRYSTAL A. MAXWELL**  
MD, MBA, FAAFP  
Chief Medical Officer  
Tricia Richardson  
CEO, SC Thrive  
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**EDWARD BEHRING, MD, FAAFP**  
Chief Medical Officer  
TAMMY GARRIS  
Clinical Data Integrity Controller  
Hypertension
**Improving Hypertension Control**

Maximizing patient visits to support hypertension management

Crystal A. Maxwell, MD,MBA,FAAFP
Chief Medical Officer

---

**The Measure**

- **Hypertension:** Blood pressure control <140/90
- **DESCRIPTION:** % of patients 18-85 y/o with hypertension who had blood pressure <140/90 during the measurement period
- **IMPROVEMENT NOTATION:** Higher score indicates better quality

**INITIAL POPULATION:** Patients 18-85 y/o with hypertension with a visit during the measurement period

**DENOMINATOR:** Equals Initial Population

**NUMERATOR:** Patients whose most recent blood pressure <140/90

---

**SMF 2011–2014 Data**

<table>
<thead>
<tr>
<th>Year</th>
<th>Initial Pop</th>
<th>Denominator</th>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>2012</td>
<td>2013</td>
<td>2014</td>
</tr>
</tbody>
</table>

- 2011: 51%
- 2012: 48%
- 2013: 55%
- 2014: 64%

---

**IMPACT**

- 2013 received PCMH accreditation via NCQA
  - 2011-2013 began assessing process and coordinating uniform processes at all sites
  - 2013 Quarterly Clinician bonuses initiated
    - 6 quality measures (diabetes, hypertension, breast cancer screening, cervical cancer screening, colon cancer screening, pneumonia vaccination)
    - 2 Additional: Closing out charts and Meeting attendance

---

**Quality Improvement**

- 2013 received PCMH accreditation via NCQA
  - 2011-2013 began assessing process and coordinating uniform processes at all sites
  - 2013 Quarterly Clinician bonuses initiated
    - 6 quality measures (diabetes, hypertension, breast cancer screening, cervical cancer screening, colon cancer screening, pneumonia vaccination)
    - 2 Additional: Closing out charts and Meeting attendance

---

**Methods**

- **Education**
  - Taught blood pressure measurement technique with nursing staff
  - Reviewed proper documentation of repeat bp reading
  - Added blood pressure measurement review to nursing yearly skills check

- **Visits**
  - Encouraged patients to take meds before each visit unless specifically told to fast
  - Nursing staff reminded to repeat bp check if bp >=140/90
  - Blood pressure log given at visits
  - Care plan with blood pressure goals and medication list given at visits
  - Clinical summary showing changes in medications given at visits

---

**Managing Barriers**

- PDSA Cycles completed 2014-2017
  - Barriers found:
    - Not taking meds before visits
    - Proper BP measurements
    - Data inaccuracies
    - Variation in follow up among clinicians
    - Medication compliance

---

**VISITS cont.**

- Encouraged Clinicians to schedule nurse blood pressure checks 1-2 weeks after the visit if bp >=140/90
- Clinicians cautioned on quantity of refills prescribed if bp uncontrolled
- Patients instructed to take meds at least 1-2 hours before nurse visit
- Red flagged message sent to Clinician during nurse visit if bp >=140/90
- Clinician may work in patient
- Clinician may send instructions for med change
- Clinician instructs next follow up
Maximizing Patient Visits to Support Hypertension Management

Edward Behling, MD, FAAFP
Chief Medical Officer

Tammy Garris, Clinical Data Integrity Controller

Optimizing Patient Visits to Support Hypertension Management

Edward Behling, MD, FAAFP

Tammy Garris, Clinical Data Integrity Controller

Our Metrics

<table>
<thead>
<tr>
<th>Measure</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure at every Visit</td>
<td>93.7%</td>
</tr>
<tr>
<td>Statin Therapy for Prevention &amp; Treatment of CVD</td>
<td>78.0%</td>
</tr>
<tr>
<td>Undiagnosed HTN</td>
<td>13.1%</td>
</tr>
<tr>
<td>Essential HTN Prevalence</td>
<td>45.1%</td>
</tr>
<tr>
<td>HTN Prevalence</td>
<td>51.0%</td>
</tr>
</tbody>
</table>

I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.
― Maya Angelou

Best Practice Ideas

- Review and analyze
- Utilize PDSA
- Reward those who are doing the work
- Don’t overlook systolic readings of 140 or diastolic readings of 90
- Integrate methods into workflow
- Utilize nurse visits for closer follow up with clinician involvement if not at goal
- Caution number of refills provided to those not at goal

Impact

- Integrate
- Methods
- Purposely
- And
- Change
- Translates

Questions? Submit on V vox for Q&A

Sandhills Medical Foundation, Inc.
68% 66% 72% 76% 77%

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ID: 136-377-847
A CHW also builds individual and community capacity by:

- Advocating or bridging gaps in care not filled by others as part of the workforce shortages
- Filling gaps in care not filled by others as part of the addressing social determinants
- Increased cervical and breast cancer screenings
- Pediatric asthma—CHWs reduced asthma symptom days and urgent care, along with a 65% reduction in hospital days. The cost savings translate into a 2:1 return on investment.
- 4:1 ROI

CHW data in SC:

- From March: 32,000+ CHWs in SC, 75% in rural areas
- CHW data in SC: CHW credentialing council: April, 2019; SC core competencies, able to approve curricula for certifying

National CHW Evidence: a snippet

- Multiple studies have found CHW programs are effective at decreasing:
  - Infant mortality
  - Chronic disease
  - Healthcare expenditures
- Clinical trials of a standardized CHW model have shown consistent improvements in:
  - Health outcomes
  - Patient-reported health
- Family Solutions of the Lowcountry: 65% reduction in African American infant mortality rate
- Birth Matters: Saved Spartanburg over $1.4 million through decreased C-sections and NICU
- Administrative savings: CHWs reduced asthma-symptom days and urgent health services use
- Increased cervical and breast cancer screening

WHO are CHWs?

American Public Health Association definition:

- A Community Health Worker (CHW) is a trusted member of a community, who has an unusually close ongoing relationship with other members of the community, enabling the CHW to serve as a bridge between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

- A CHW also builds individual and community capacity by:
  - Coaching, social support, and advocacy.
  - Activities such as outreach, community education, informal delivery.

Why CHWs NOW?

- Increasing spending on healthcare without improved results
- Workforce shortages
- Move to value-based care
- Recognition of importance of addressing social determinants and non-medical needs
- Ability to fill gaps in care not filled by others as part of the care team.

The Need for More CHWs in order to Impact Health

Recent Mentions—South Carolina

- SC OFFICE OF RURAL HEALTH'S RURAL HEALTH ACTION PLAN
- TRUSTED MEMBER OF COMMUNITY
- INTEGRITY
- CONNECTED/REASSURING
- RELATIONSHIP BUILDER
- FLEXIBILITY
- DEDICATION
- TEAM PLAYER

Core CHW roles

- Advocating individual and community needs
- Building community capacity
- Case coordination (case management, care navigation)
- Health education and outreach
- UCLA Health, Healthier Communities:

Why CHWs?

- Ability to fill gaps in care not filled by others as part of the care team.
- Recognition of importance of addressing social determinants and non-medical needs
- Workforce shortages
- Moving to value-based care
- Ability to fill gaps in care not filled by others as part of the care team.

CHWs in SC now

- CHWs in some SC: 75% in rural areas
- Community Health Worker Institute—as of March, 2019
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Training and Curriculum Development

- High quality core competency training to CHWs based on national and state standards
- Training focused on skills and social determinants
- CHW Supervisor Training
- Continuing Education
- Specialty Tracks: MCH, LGBTQ, rural health, chronic disease, oral health, others
- Train-the-Trainer model for statewide training availability
- Mobile, multi-cultural program

EVALUATION

- CHW is collaborating with five pilot sites in SC to evaluate the ROI for systems of care utilizing the CHW model
- The five programs are being evaluated for approximately two years. Data will be collected and analyzed on outcomes related to patient health outcomes, upstream prevention activities, social determinants of health, health education and behavior change, patient engagement, and others.
- Data Experts Council: think tank focused on data collection and data for CHW planning

Development of Reimbursement/Payment Models

The Institute is working with current and potential payers to determine the feasibility of new models to cover CHW services.
Partners include: SCPHCA, DHHS, SCHA, MCOs, The Duke Endowment, BCBS of SC, BCBS Foundation of SC, the Alliance, DHEC.

TECHNICAL ASSISTANCE

- Training and technical assistance to health and other organizations on developing CHW programs
- Integration of CHWs into models of practice and health delivery teams utilizing best practices
- CHW data extraction, data set development and evaluation design
- Development of a CHW Toolkit
- Best practice expertise informed by Best Practices Experts Council

Q&A

Contact Information

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Lunch & Networking

Use Zoom Private Chat to Connect

Meeting Resumes at 12:30 pm

Kickstart to Resume

Afternoon Breakouts / Facilitated Discussions

JOHN BARTKUS
Principal Program Manager
Pensivia
Breakout Workgroups

<table>
<thead>
<tr>
<th>Breakout Session Topics</th>
<th>Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing Patient Engagement</td>
<td>1A, 1B, 1C</td>
</tr>
<tr>
<td>Collaborating with Community Partners</td>
<td>2A, 2B</td>
</tr>
<tr>
<td>Maximizing Patient Visits</td>
<td>3A</td>
</tr>
</tbody>
</table>

Workgroup Objectives

- What's working well? (~15 mins)
- What are the key challenges? (~15 mins)
- How might we address these challenges? (~15 mins)
- What other opportunities do we have? (~15 mins)
- What do we choose to do next? (~10 mins)

Individual takeaways: (~5 mins)
- What new strategy did I learn today?
- What new partners have I identified today with whom I can work to further my/their goals?
- What are two things I can implement to employ new patient engagement strategies?

Workgroup Mechanics

- 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 action required)

Common Strategies and Themes

SHARON NELSON
Program Initiatives Manager, Million Hearts® Collaboration
American Heart Association

Next Steps

SARAH MILLER COCKRELL
Manager of Clinical Quality Improvement
South Carolina Primary Health Care Association

Adjourn

JOHN CLYMER