Robin Rinker: Thank you so much. Good afternoon, everyone, or good morning if you're on the West Coast. This is Robin Rinker with the Million Hearts team here at CDC, and thanks for joining our quarterly Million Hearts private partner call. As a reminder, these partner calls serve as an opportunity for you to stay in touch with what's happening in the federal sector, amongst your peers in the private sector, and there'll be an opportunity for you to contribute to the initiative.

We hope to have you contribute presentations and updates to this in future calls. There will be a time set aside during this call for you to share what your organization's doing in the Million Hearts arena. And, as a reminder, this event is being recorded for rebroadcast. You will receive access to a live recording and transcripts, and they will be available on the AHA Million Hearts webpage, and you'll get an update about that after today's call.

So, we encourage you to contribute and to submit written questions at any time during our presentations today, using Q&A panel located at the bottom right of your screen. After typing your questions in the space at the bottom, hit the Send button, and your questions will be seen by the panelists and the host and addressed after the presentations today. We also encourage you to submit updates from your organization later in the call using the same method of typing into the Q&A box. As some of you who were on the call in October might remember, we had some technical issues with the phone lines, so we're gonna try and rely a little bit more on writing updates in the Q&A box this time.

So, today, we are going to delve into the Million Hearts 2022 priority populations. So, we'll take a deep dive into African-Americans with hypertension and 35 to 64-year-olds at risk of heart attacks and strokes. And we're really grateful to have a great lineup of speakers today—Janet Wright, Executive Director for Million Hearts; Letitia Presley-Cantrell, from our own Division for Heart Disease and Stroke Prevention here at CDC; Heather Hodge, Director of Chronic Disease Prevention Programs for Y USA; and Dani Pere, Associate Executive Director of the American College for Preventive Medicine—and bios for each of these speakers are included with your agenda.

So, with that, I'm gonna turn it over to Dr. Janet Wright to give us an introduction to priority populations in Million Hearts. Janet, over to you.

Janet Wright: Thank you so much, Robin, and thank you, April and Julie, for setting us all up for success today. I am very excited about today's call and the topic that we're going to be discussing. We're going to hear from some exemplars in this field who will share their experience with us and hopefully pave the way for us to make more progress faster.

But the first thing I've got to do is to introduce the new Director of the Division of Heart Disease and Stroke Prevention at CDC. Dr. Betsy Thompson is just beginning her second week of work in the Division at CDC, and everyone is celebrating her arrival and pummeling her with lots of information. We are delighted that she can join us. I just want you all to know, it's as though, looking in the rear view mirror of her career to date, that she was made to lead Million Hearts and all of the work of the division.

But she started her career, one of the earliest things on her CV is a health educator and water technician in Liberia and Guatemala, and she moved from there to practicing medicine in both Colorado and California. She's worked on guidelines. She has served in health plans and, more recently, she was a Chief Medical Officer with CMS in Region 9 out West in San Francisco and also did a residency in preventive medicine. She has training in epidemiology as well as primary care. And she comes to us from being the Deputy Regional Health Administrator, again in Region 9 in San Francisco, and also served as the Acting Director there.

So, it is with great joy that I turn it over to Dr. Thompson—Betsy, are you there?

Male: I do not see Betsy on the call at this moment.

Janet Wright: Okay. Well, she's gotten a warmup, and when she appears, *[Laughter]* just let me know, we'll surge ahead, but I know she's looking forward to joining us when the schedule permits.

So, let me take us back to the framework for Million Hearts 2022, and our topic for today, as Robin said, we're going to focus in on two of the four priority populations in this five year phase of the work. Let me remind you that the Million Hearts

team used three criteria to select populations for us to concentrate on, for us to put extra energy and focus into, and the two that we'll talk about today are blacks and African-Americans with hypertension, because we know that, although there has been increased awareness and even increased treatment in recent years, the control rates are still lagging behind, and that has a huge impact on outcomes. The second group that we'll talk about today and that will be a focus for us going forward are 35 to 64-year-olds where we are seeing a rise in event rates, particularly in death rates from cardiovascular disease.

We'll go into a little bit more detail about that in a moment. But again, the criteria for selecting the four subsets of the population that we choose were (1) the presence of a significant disparity in outcomes; second criterion are interventions, either already proven or very promising interventions to impact that disparity; and the third are partnerships that are very well positioned to interact with and reach the population in question.

So, this slide shows the strategies that we have selected. These, again, have come from the literature, come from subject matter experts, and come from high performers. These are not the only strategies, but these are specifically ones that we will be pushing and help to drive forward over the next remaining four years.

So, again, with blacks and African-Americans, it’s a heavy focus on improving control. We know that tailored protocols are one way to accelerate and get to higher control rates faster. The proven strategies to help improve medication adherence are on the list, and I would also add to this, advancing the practice of self-measured or self-monitored blood pressure. And, with the 35 to 64-year-olds, when we look at the data, we see that those who are eligible for both pharmacologic and non-pharmacologic treatment of hypertension and elevated cholesterol are lagging behind receiving those treatments compared to older age groups. So, not optimal—they're not getting optimal management of both hypertension and cholesterol elevation. And we see a fairly high rate of physical inactivity in that age group.

You see the strategies that we mentioned, and I would include—because we've seen persistently high rates of tobacco use in this age group, that is also likely influencing the event

rates. So, protocols, as you know, we have them available on our website and there are many others for hypertension control, cholesterol management, and smoking cessation.

We know that when it comes to physical activity, large gains can be made by implementing community design, increasing access, and also relying on peer group support for helping us all maintain physical activity.

So, I want to march through some of the data that we have. Now, these hypertension data are prior to the change in the guideline target, so we are still working with the prior target, and it's definitions of prevalence. But you see, the control rate is still perilously close to 50 percent for hypertension across the entire population. When we divvy that up into those who are aware and treated, you see the great bulk are aware and treated, but there are still a significant number of people who are unaware of being hypertensive and having uncontrolled hypertension and aware and untreated is still not an insignificant number.

If we hone in on blacks and African-Americans, you see that the control rate is actually below 50 percent for the 11,000,000 people. When we look at those who really draw, focus in on the uncontrolled, the 6,000,000 African-American or black people with uncontrolled hypertension, you see there's actually an increased number who are aware, or a percentage that are aware and treated, but we have still a very large number unaware and untreated. These are opportunities to impact not only, of course, the hypertension control rate, but more importantly, the rate of stroke, the rate of kidney disease, and the rate of heart attack and heart failure, all entirely too common in this population.

As you all know, while all of you have been hard at work in trying to improve cardiovascular outcomes, we are dealing with a strong headwind. This graph depicts the last 40—60 years, actually, of data on cardiovascular disease, coronary heart disease, and stroke, and you see there has been an extraordinary flattening in that deceleration that we have enjoyed for many years before. We believe, and many people published on this, that what we're seeing is the impact of decades of diabetes, physical inactivity, and obesity showing up in increasing event rates and increased death rates. This, actually—this slide is one that keeps me awake at night. *[Laughter]*

We're gonna move now to looking at the 35 to 64-year-olds. There is a lot of data, there are a lot of data on this slide, but let me just bring you home to the red zones. Those red zones are counties in the U.S. that are seeing a rise in death rate from cardiovascular disease in the age group from 35 to 64. That's over the period of time of 2010 to 2015. The gray areas have seen a drop in death rate in that age group, and then the redder it gets, of course, the higher—the more rapid that change in death rate.

This is an extraordinarily frightening slide, particularly when you see that this change has occurred all the way from Maine to California. It is no longer confined, as it has been for so many years, to the Stroke Belt.

Moving on here, one more slide looking again at blacks and African-American, but also looking at the age group distribution. And you see that, for both stroke and high blood pressure, African-Americans have a higher burden of disease developing at a younger age than whites. An extraordinary opportunity, with these conditions, that are highly treatable, highly controllable. That is the business that we are all in, and it gives me great hope that, because of working across all of our partnerships, that we will be able to accelerate control rates and protect people from these preventable events.

So, with that, I'd like to make sure and see if Dr. Thompson has joined us. Betsy, are you on?

Okay, well, then, I have the pleasure of introducing my esteemed colleague and friend, Dr. Letitia Presley-Cantrell. Letitia?

Letitia Presley-Cantrell: Thanks, Janet. So, good afternoon, everyone, and I want to thank you all for the opportunity to present today to talk about some of the work that we're doing in the Division of Heart Disease and Stroke Prevention in the Program and Development Services Branch.

Okay. My clicker was not clicking with me, so I think we've got that fixed now.

So, the Division for Heart Disease and Stroke, most of our primary constituents and the bulk of our funding is awarded to our state and local health departments. And we work very

closely with them on our strategic aims and our priorities in the division. So, here, as you see on the slide, I've listed our priorities and the areas that we work in. We also, in addition to funding our state and local health departments, we award funds to our national organizations which work with us to support and enhance our work in the field.

So, our awards are strategically funded to work in these priority areas, and most of our goals are centered around the use of evidence based approaches to improve the prevention, detection, and control of hypertension. We identify and build networks and cross-sector partnerships, and we test models of collaboration between public health, health care, and community partners which strengthens our community clinical linkages.

Here on this slide, you know, you'll see what we typically do with our public health approach. So, we are either targeting an approach to reduce health disparities, or we sometimes use what we call a broad approach to achieve population wide impact.

Okay. So, here, as you can see, we really employ in the Division what we call the dual approach. And the dual approach, as you can see, is the general population strategies and interventions and targeted interventions for priority populations which compromise what we call this dual approach. So, we're doing both/and and not either/or in what we consider the classical approach of this.

The primary goal of using the dual approach is to reduce the health related disparities and to improve health equity in our targeted areas. We use the dual approach with our state and local work. We also use it across our sectors in terms of the work we do with our national organizations and underfunded entities. So, the dual approach is built off of our social ecological model and our targeted universalism. So, those two theories along with this work of what we use in terms of our dual approach.

So, I wanted to show you a map of the funding that we've put out in the Division for the program's Development Services branch. And this kinda highlights some of the work across our funded national work in terms of our national program, our work with our Indian country and tribal organizations, also our work in our WISEWOMAN states. We also fund, again, Y

USA, Y of the USA, and the ASTHO Heart Disease Learning Collaborative as well as the Mississippi Delta. You'll see additionally we have a lot of work going on in Pacific Island Associations, and we do work with Palau, Guam, CNMI, in addition to the Virgin Islands and the work that we are doing in the Pacific.

So, the reason I want to show you this map is because the presenters that you'll hear today are part of the additional funding that we put out to enhance the work of the Division that we have here—I'm sorry, to enhance the work of the Division of Heart Disease and Stroke Prevention.

So, today, you'll hear from two of our national organizations that, like I said, help us to improve our efforts around cardiovascular outcomes. So, we work with both of these entities to strategically place services in areas that experience the greatest disparities. And so, building off of what Dr. Wright has said earlier, the work of these entities helps us to target those populations that are disproportionately affected by heart disease and stroke.

So, first you'll hear from Miss Heather Hodge of YMCA of the USA, and she'll discuss their blood pressure monitoring—self-monitoring program. And this program was based on findings from AHA's Check.Change.Control program and received funding from Million Hearts as well as additional funding from the Division of Heart Disease and Stroke Prevention. YUSA has been able to expand their blood pressure self-monitoring program to increase the availability of a hypertension lifestyle program nationally. Now granted, they aren't, as you look at this map, in all areas, but we've definitely increased the availability of programs for our lifestyle programs that focus on hypertension.

Our second present is Miss Dani Pere, and she is with the American College of Preventive Medicine. Miss Pere will discuss the American College of Preventive Medicine's upstream prevention Lifestyle Medicine Core Competencies Program. We've also worked with ACPM to develop and disseminate a lifestyle medicine module which specifically focuses on hypertension and the original targeting of that work was with our WISEWOMAN clinical providers.

So, again, we have two very excellent speakers that will talk about some of this very focused work for these disparate

populations. And so, with that, I'm gonna now turn it over to Miss Heather Hodge.

Heather Hodge: Thank you, Letitia, and good afternoon, everyone. We are excited to talk a little bit about what we've seen in the YMCA, and I think one of the benefits of—sorry, skipping through a couple slides, here. One of the benefits of the Million Hearts work and the work that we've had alongside CDC is that, by participating in these Million Hearts partner calls, we are having a conversation around what we might be learning or observing, and it really got us to thinking about these specific target populations and what we were seeing.

So, just a couple background, as Letitia mentioned, we have definitely—we don't have this program everywhere yet, but we wanted to give a little bit of context. The YMCA's blood pressure self-monitoring program is really a four month program that's delivered one on one with a participant who works with what we all a Healthy Heart Ambassador, and that Healthy Heart Ambassador really helps the participant self-monitor, measure, and track their own blood pressure at home, reinforcing what they're hearing from the physician.

It's open to any community member. You don't need to be a Y member to participate, but in addition to helping to teach proper measurement techniques and model that with the participants and talk about the things that impact blood pressure, we also provide a monthly nutrition education seminar that focuses in on the DASH diet so that we're helping to reinforce the behaviors that the physician is likely speaking to the participant about in terms of their better blood pressure management.

Who qualifies for the program overall? We have a broad—so, this is, you know, using what Letitia shared earlier, this is probably the broad approach. We have participants who are 18 years of age or older who have been told they have blood pressure or may be on an anti-hypertensive. We have a couple of things that would have someone not qualify for the program, so if they've experienced a recent cardiac event or have atrial fibrillation or any arrhythmias or might be at risk for lymphedema, a physician's referral isn't required. Although, what we find is, the majority of our participants do come to us, they probably fit in what Dr. Wright was sharing as the folks who are aware. So, they come to us from that bucket, so usually the physician is engaged. And medical clearance isn't

required. Again, we're really focusing in on helping the participant really make sure they understand how to take their proper blood pressure and some of the variables that can influence our blood pressure over time. We all know that the behavior of just monitoring your blood pressure can lead to some blood pressure improvement.

So, what we're seeing, we looked at the target populations that we talked about in the start of the call, and overall, in our participants, about 31 percent of the participants are African-American, and the reason I also show some of the white participant numbers here is just so you can see, in the subsequent slides, just the difference in the variation of the data. So, this is really looking at it from an outcomes perspective, and I'll try to sprinkle in along the way some of the actual activities that we've been working either alongside CDC or the American Heart Association or the American Medical Association or others to try to impact the target populations that we've been working to support.

So, this is a little bit of a busy slide, but essentially, I think, to get to the meat of the slide, you can see here change in the diastolic and systolic blood pressures in African-American participants tends to be statistically different from that in the white participants, especially when it comes to diastolic blood pressure change. So, we do see a decrease in both systolic and diastolic readings, but it’s significantly different in diastolic numbers. So, this just gives you a snapshot of that.

You can also see, as we're looking at—we are starting to slice and dice our data based on the new guidelines. So, what we wanted to do here is just show how many participants are starting the program with uncontrolled blood pressure. So, that’s, their baseline reading would be an uncontrolled reading. We do see a great proportion of the population that we're serving, African-Americans have a higher percentage starting uncontrolled. And then we look at the last reading that we took of them.

So, in addition to supporting their readings at home, when they meet with their Healthy Heart Ambassador, we're observing a reading there, so we're taking one there. Then you can see that the percent that are uncontrolled that gained control during that four month window. So, this tells us that we have some work to do. We know that a larger percentage of the participants who are African-American are coming uncontrolled, and while we

do see 15 percent gain control, we know we have work to do to understand where some of the variation is. And this is the work that we've been doing alongside CDC to really dig in around some of these things.

We know that we have, in addition to the work that has been supported, we've been working to build capacity in some of our locations and states where capacity building is always a need to support the blood pressure. So, that tends to be more in the Stroke Belt. We've also seen YMCAs working with their WISEWOMAN clinic partners to try to really make sure that we're addressing target populations through those partnerships as well.

And then we looked at age, because we wanted to understand what some of the age breakdown was. And we hear—one of the questions I had was, based on the percentage of the participants that we were seeing that were either white or African-American, where did they fall from an age perspective, and then also, where did they fall from a gender perspective? Because we wanted to make sure, again, that we're serving populations who are at some of the greatest risk.

So, you can see here that we do trend more female than male. That's probably not surprising. A lot of behavior tinged programs do tend to trend that way. But we can see about 76 percent of the participants who are African-American are female, and then you can see the age breakdowns here. And then another slice of the age breakdown, just by race overall, I thought it might be helpful for folks to understand—as we were looking at the participant data for the folks who are coming to the program, we saw, in African-Americans, a larger percentage that were in the 35 to 64 than we did by comparison to a white population where we saw a larger percentage coming from those who are 65 plus.

Again, this leads to a lot of questions on our team and so, more opportunity for us to learn alongside partners and dig in on this. I thought that might be helpful context as we look at—again, when we look at that 35 to 64 age range, this was definitely new for us to kinda dig in and explore data based on the opportunity to talk with all of you today. Fifty one percent of our participants are coming from this. Now, I don't know if that's a result of the increasing red that was on the map that Dr. Wright showed, or we're just finding that this is a population

that's easier to engage—I honestly don't know the answer to that yet, but it definitely leads us to more questions.

The other piece, here—we do see, in terms of attendance and ongoing support in the four month program, the engagement in the program that, while we know more of our participants are in the 35 to 64-year-old range, the actual compliance with the intervention itself, we see more compliance with those who are 65 years of age and older.

I do have a slide in here that defines enrollee to starter and start to completer. I won't spend time on it today, but as you look through the slides after the presentation, you'll have some definitions there. So, while we know that the bulk of the participants, 51 percent, were in the 35 to 64-year-old—you know, those individuals who are more compliant with the intervention and attend more and engage more are actually 65 plus.

I did also want to just show some of the outcomes by age group, so you could look at uncontrolled at baseline, the percentage of the participants who are coming on blood pressure medications versus those who—and then the percentage of those who, their final reading shows that they are in a controlled range for their blood pressure, and then the change in systolic and diastolic blood pressures. Again, some pretty interesting numbers here that we saw, you know, less control at baseline in those under 65 compared to those over 65. We saw, obviously, more medication usage in those over 65, although a pretty significant percentage in those 35 to 64. And then the control, again, those whose final readings, you can see that that does vary by age range as well.

So, while you all might be looking at this thinking, "Well, this is really interesting. What are you gonna do to learn more about this?"—that's part of what we are working with both CDC and others to really have an understanding of what is, what's driving some of these changes. Is it the readiness for change, is it the amount of time they've been on blood pressure medication, is it the engagement of the physician? We've been looking at a lot of this different data, and we will continue to do so.

I wish I had—I mean, I think we probably all wish there was some one simple thing if we just all did, we would be able to tackle this around the country, but as we all know, that's just

not the case. So, this is a snapshot of a single organization who's been delivering this type of intervention in many locations around the country. It's just another data point in all of our efforts to try to improve and achieve the Million Hearts targets.

I did want to just show a little bit of the data broadly across so that—you just saw some data on the specific target populations, but we are now, with the help of CDC and American Heart Association and some others, in 80 of our YMCAs around the country, across 28 states, we have 810 of our staff who have been trained to be Healthy Heart Ambassadors and serve just over 4,000 participants.

So, when you saw the percentage of the participants, 31 percent were African-American compared to whites or other populations, we know we have work to do to make sure we're addressing the target populations for Million Hearts. But this is still a very new program for us in terms of the scale around the country, and we'll continue to learn as it grows.

I did just want to share, we do ask participants if they will continue to monitor their blood pressure beyond the program and how they feel that they made in terms of their progress towards their general, overall health and well-being goals. And you can see here that 94 percent of them continue to self-monitor their blood pressure after they have finished their work with their Healthy Heart Ambassador. We know that they will continue to go back to their physicians and constantly be encouraged, again, to be monitoring their own self blood pressure. But this just gives you an idea of some of the progress that we've seen with our participants and their self-reported behavior changes.

Here's the data definitions slide. Again, I'm not gonna spend a lot of time on it, but just wanted folks to see that it was in here. And then the last one, just—you know, one of the things that I think isn't gonna be new to anybody, but I always feel like is worth sharing is just, there's more work to be done to not only educate health care professionals, but also the community about the benefits of self-monitoring blood pressure. I know physicians understand that importance, but the understanding of the ability to have a referral to a community organization to support the patient in their self-monitoring of blood pressure, especially under the new guidelines with the increase in lifestyle counseling for the new individuals who might be

hypertensive that didn't know they were before? There's just a huge opportunity for us to help engage and educate professionals as well as the community about the opportunity for those lifestyle behavior changes, whether it's physical activity or other to make sure that we're addressing that.

Additionally, there are lots of opportunities among multiple communities for lifestyle support, so, finding out where—what those are and helping to get folks connected to the right sets of services. And then if—you know, we have different folks on the line who might be wondering, "Does my YMCA have the program? If not, can I get this Y to the program?"—we have more information here at this website. I also have my information connected on here. Feel free to reach out. We can get you connected to your local Y. If it's something that you have an interest in learning more about, that we can definitely make happen.

And before I turn it over to Dani Pere, it looks like we may have, Dr. Thompson has been able to join the line, and if that's right, I just probably need to know who I'm gonna turn it over to.

Male: Dr. Thompson, you are able to speak, correct?

Betsy Thompson: Yes, I am.

Male: Okay.

Janet Wright: Welcome, Dr. Thompson. This is Janet. Everyone has heard a little bit about you. We've been waiting and enjoying wonderful presentations. Glad you could join.

Betsy Thompson: Thank you, and I'm happy to be able to join for, actually, starting with Letitia. The rest of you on the line, you don't wanna know what's been going on in my office in the background, but leave it to say, it's been a little hectic of a day, but I now have my belongings in my office, albeit all in boxes.

It's a real pleasure to be able to join the partners' call, however briefly, and I'm not sure exactly what you've heard about me. I have been with the federal government in a number of different positions with both the Office of the Assistant Secretary for Health, CMS, and previously with CDC, but I've also spent time in the private sector as the Chief Medical Director of a

health plan, and also working with several nonprofits in the health space.

So, I come with a varied background, and I'd like to think a bit of understanding of some of our partners and their perspectives. I really look forward to learning more about all of you and I appreciate your participation in Million Hearts wholeheartedly.

I will stop there because we've got a full agenda, but it's just great to be on board, and thanks for your participation.

Dani Pere: Thank you, Dr. Thompson. This is Dani Pere with the American College of Preventive Medicine, and I'll take it from here.

So, I'll just start by saying that ACPM is a long-time supporter and champion of the Million Hearts campaign. So, it is a real pleasure to present to all of you today, and also a pleasure to listen and learn from all the speakers and all of you who will be speaking as well with your updates, so thanks for joining.

The focus of this part of the conversation is going to be on how we build clinical competencies for physicians, really thinking about how we equip them with competencies to improve the outcome for priority populations for the campaign.

So, I just want to pause for a moment and have us all just remember the goals of Million Hearts 2022—so, keeping people healthy, optimizing care, improving outcomes for the priority populations.

Now I want you to pause again, and I want you to think for a moment about your own personal health care provider—maybe your physician, maybe you see an NP or a PA, your relationship with them, how you may have worked with them over the years. And think about, if you believe they're actually trained to take care of the priority populations, if they've been trained to really meet the goals of Million Hearts 2022. Now, some of you may say, "Yes, absolutely. I've seen that. I've seen them do that." Others of you may pause and think, "I don't know."

Some of you might say, "My provider? Definitely not." And so, at ACPM, what we're really doing is working to change the

culture of American medicine to focus more on lifestyle and in many ways, this supports the goals of Million Hearts 2022.

But first, if you're not familiar with ACPM, I just wanna do a quick introduction. We are a national medical specialty society that represents physicians who work at a very unique intersection of clinical care and population health, and that we see lifestyle medicine as a true core concept of preventive medicine.

So, you may be asking, “Well, what is this lifestyle medicine? I've never heard of that concept before.” So, we define it as an evidence based, therapeutic approach to prevent, treat, and reverse lifestyle related chronic diseases using lifestyle interventions and behavior modifications, and looking specifically at lifestyle factors such as nutrition, physical activity, mindfulness, sleep, et cetera.

Now, this happens to be all the factors that physicians are not usually trained on in medical school or residency. And if you look at the bottom right there, The Invisible Backpack—physicians are especially not trained on this.

So, what is The Invisible Backpack? We want to change the culture of American health care to get physicians and clinicians in a 10 or 15 minute clinical encounter, which is more often than not how much time physicians spend with patients—we want that physician to view a patient with an invisible backpack. Meaning, when a patient walks into the office, can a physician think about, “Well, how long did it take my patient to get here this morning? Was it an easy 10 minute drive from their home, or did they have to take 2 train lines, a bus, and maybe walk for 15 or 20 minutes? Is this patient, are they taking uncompensated time off of work, or maybe they've left a child back home that is unattended to and they're worrying about it?”

Can the physician think about whether the patient might actually have the financial resources to pay for a prescription that would be prescribed or even enough money for the co-pay? So, really, really getting physicians and clinicians to think about that built environment, the social supports—all the things that could potentially go into that invisible backpack.

So, what did we do, knowing that physicians in general are not trained in lifestyle in the U.S.? Back in 2016, ACPM and our

sister organization, the American College of Lifestyle Medicine, created a first of its kind medical education curriculum on lifestyle medicine to address all of the knowledge and the skill gaps that we now that doctors have cited about why they can't prescribe lifestyle interventions, behavior change interventions. And the curriculum is 37 hours of CME, and it focuses on how to incorporate lifestyle medicine into someone's current clinical or population health practice.

Now, we started developing this curriculum about six years ago, and during that time, there was no MACRA and there was no MIPS, but what we found as we followed the legislation and followed the new reporting requirements, the good news is that lifestyle medicine actually supports this new shift towards value based care.

So, what's in the curriculum? The curriculum covers 15 core competencies in prescribing lifestyle medicine, which I'll go over in a minute—nutrition, physical activity, sleep, and electives. But there's three that I want to highlight. Nutrition—so, when we think about the Million Hearts priorities in terms of reducing sodium intake, decreasing tobacco and increasing physical activity, that is all a part of the curriculum. We've been lucky enough to be funded by the CDC to develop four new elective modules, while I'll go over in greater detail in upcoming slides on CVD and stroke prevention in underserved populations.

So, how did we create this curriculum? Back in 2010, ACPM, we convened a Blue Ribbon Panel of eight professional medical specialty societies that really looked at what physicians were citing as a gap in their own education and training. And through identifying those gaps, the Blue Ribbon Panel developed 15 physician competencies for prescribing lifestyle medicine, and this forms the base of the curriculum.

So, the curriculum is much needed, both for residents, graduate medical education, and practicing physicians, and it really supports the Million Hearts strategies for optimizing care in terms of technology, care teams, processes, and patient and family supports.

Now, the 15 physician competencies were published in *JAMA* back in 2010, and then in 2012, the ACPM worked with the American Medical Association to adopt a resolution in the

House of Delegates that really urged physicians to use lifestyle medicine as a frontline therapy.

So, I just want to talk a little bit about the adoption of the curriculum and how it's currently being used. So, the curriculum is being taught at the Cummins Corporation, and all their physicians and clinicians in their network. The Cummins Corporation, if you're not familiar with them, it's a large international engines manufacturer based out of Indiana that has a very large and diverse workforce, and they are very interested in training their own physician and clinician workforce on how they can drive down chronic disease and ensure a healthy workforce.

The curriculum is also being used by 17 preventive medicine residency programs across the country. It's being used at 2 major U.S. integrated health systems, and it's being used by about 850 individual U.S. learners, primarily physicians who go onto our learning management system and access the curriculum.

In the public sector, the Lifestyle Medicine Core Competencies Program is being used by WISEWOMAN providers, so physicians, nurse practitioners, PAs that interact with the WISEWOMAN beneficiaries, and we're very grateful for CDC funding to be able to develop those elective modules. The curriculum is also provided as a grantee benefit for the CMMI's Million Hearts Innovation Awardees to really help train those clinical practices that receive that grant how to best identify CVD risk and also curtail it using lifestyle change. The curriculum also appears in the NIH's Foundation for Advanced Education course catalogue.

Okay, so I just want to take a moment to dig a little bit deeper into the priority populations. ACPM has been funded by CDC's Division of Heart Disease and Stroke Prevention to develop four continuing medical education models that appear as electives in the overall lifestyle medicine curriculum. These were developed specifically for WISEWOMAN providers, but they really can be used by any provider that is working with the priority populations. And these are very important to the Million Hearts goal of optimizing care when we think about how to engage patients in heart healthy behaviors.

These modules also really relate back to when we were talking about The Invisible Backpack. So, thinking about CVD risk in

a unique environment with the priority populations—so, how do you manage CVD risk on the spectrum of socioeconomic status, ethnicity, cultural readiness to change, et cetera? So, these modules are meant to review the latest case studies on using lifestyle to improve hypertension and CVD outcomes, practical tips for implementing the lessons of these studies, again, managing patients across a variety of priority population spectrum.

And module four is very, very important—case studies of patients who represent typical target populations. So, a physician may have all the knowledge and competency about the studies and know the science and the evidence, but how do they actually engage that patient? How do they actually do motivational interviewing or assess readiness to change? And those are the case studies.

We have our second phase of our work with CDC's Division of Heart Disease and Stroke Prevention with Dr. Letitia Presley-Cantrell. We've just released a call for funding or call for award where ACPM will be awarding two grants to clinical care organizations to really implement and strengthen strategies to increase hypertension awareness, screening, and referral to evidence-based programs. These grantees, who will be announced in February, will really work with ACPM and CDC to develop tools and resources, including case studies, physician education materials, and provider workflows, and this work will be presented at the ACPM annual conference.

Okay, speaking of the annual conference, we'd love for all of you to join us at our Preventive Medicine Annual Medical Conference in Chicago, May 22nd to the 26th. This is, again, we're gonna be hearing from our grantees about what really worked in the front lines in the field and case studies that we could all learn from. We also have a Healthy Aging Summit coming up that we're co-sponsoring with HHS, and abstracts are still being submitted, but we will undoubtedly have sessions and concurrence on the priority populations related to CVD risk and the Million Hearts goals.

Okay, so as I said at the beginning, ACPM is very focused on changing the culture of American medicine. So, what does that look like? Maybe in 10 or 15 or 20 years, it looks like this, among many things. So, a prescription on nutrition and a prescription on exercise that might just be just as common as a prescription for a pharmaceutical.

And with that, I'll close, and I would just say, we would love to have you join us on this journey. We work with many of you on the phone, including CDC and the YMCA. It's a long journey, there are lots of challenges, but we have a lot of tools and resources, thanks to our federal partners, to get great work done. So, thank you very much, and with that, I will now turn it over to April Wallace to facilitate the Q&A session.

April Wallace: Thank you so much, Dani. So, we've heard two wonderful presentations today, and so, at this time, we would like to know if you all have questions for our speakers. We will take questions, you can submit them online using the Q&A panel, it's located at the bottom right of your screen. So, if you have any questions, we'd love to hear from you.

Looks like we have our first question here. It says—this is from Kelly Robinson. It says, "Where are these numbers taken from, aware and untreated?" and I'm not sure who this is for in particular. Kelly, could you specify for which presentation? I'm thinking probably the Y.

Heather Hodge: Actually, I was gonna guess it was Dr. Wright. *[Laughter]*

Janet Wright: Yeah, I was, too. Those are NHANES data.

April Wallace: Okay. Thank you. Are there any more questions from our audience, our participants, for our speakers?

So, I have a question for ACPM. Are more courses planned that are focused on utilizing lifestyle medicine in the priority populations?

Dani Pere: Okay. This is Dani with ACPM, just unmuting myself. So, we are currently evaluating that. The curriculum has been out since 2016, and one of the things that we're learning from our current participants is, they definitely want more electives or more base training like the CVD modules that CDC funded. Especially working with these topic areas, not so much, again, on the science and the evidence, because they know it, but giving them the tools and the resources to engage with the priority populations and giving them case studies and helping them more with role playing and how do they really fit this work into that 10 or 15 minute clinical encounter can be very challenging.

So, we are working probably within the next year or two to provide more modules that would focus on the priority populations and providing physicians and clinicians those skills for interaction more around assessing readiness to change, the motivational interview, role playing with the patients, et cetera.

April Wallace: And Heather, I can see that you're answering a couple of *questions* online. I just want you—I'll read this one out loud, we have a couple of minutes. "Specifically referencing the YMCA presentation, have you looked at the role of medical mistrust in engaging with people who identify as black or African-American and are 65 years or older?" So, if you could just kind of repeat what you've typed in here, that would be great.

Heather Hodge: Yeah, no, thank you. I've had to do this a few times on webinars. But yeah, no, this is a really good question and not one that we've dug into specifically, not in that way. But we are getting reading to do some focus groups, and so I think it's a good opportunity for us to also address that piece of part of the focus group. And I really appreciate Kelsey for raising the question, because it isn't one we had looked at even at this point in time, but I think we can raise that question as we're conducting those focus groups, so thank you.

April Wallace: I'd like to say thank you to our speakers. Since we have about five minutes left, I'd like to go ahead and move through our agenda pretty quickly. I'm going to now turn this over to my colleague, Robin Rinker from CDC to give us some announcements around—from CDC. Robin, are you there?

Robin Rinker: Keep the questions coming. You know, you can keep typing in the box, and we'll either get them answered during the call, or we'll make sure we send them to you.

So, I just want to give everybody a quick update about what's going on here at CDC and with Million Hearts. As you might know, February is American Heart Month, and that is right around the corner. So, I'm gonna give you a little hint about what we'll be doing, and also some other things happening with our sister agencies in the federal space.

So, we are—this actually jives really well with our call. We're gonna be focusing on encouraging adults to prevent heart disease at any age. And so, some things that you can do to get involved, we encourage you to visit our event page at

MillionHearts.hhs.gov to find some key resources, some charitable social media content to use in your own channels, and we'll also be releasing some new social media animations coming very soon.

We are gonna be doing a Facebook challenge throughout February, so each week, we'll pick a specific topic like healthy eating and ask people to comment and share how they're taking control of their own heart health, so, join in. That challenge begins on February 5th.

And this is kind of our big ticket item, we hope to have all of you tune into this—on February 20th, we will be doing a CDC Public Health Grand Rounds on Million Hearts 2022. And this is going to be webcast live at 1 p.m. Eastern, so mark your calendars to tune into that. We'll make sure you all get the link to either view it on the web or come to a viewing party; there will be several of those across the country, and feel free to host one of your own.

And then some of our sisters across the federal government are doing some things for American Heart Month. EPA is writing a blog on particle pollution and cardiovascular health, so read that and share it with your constituents. And then participate in NHLBI's pledge to stay active. So, they're gonna be sharing, post photos and videos about how you and your colleagues in your organization are staying active this February. So, use the hashtag #movewithheart to join this conversation, and they have a really cute video that you should go check out.

And then I'm gonna just say one action that everybody can take to get involved in American Heart Month is to host some Million Hearts tools and resources for clinicians on your own website. So, we do have syndicated content available for you to use and host. It is updated on our end, so no need for you to keep content current, you can just put our microsite on your site and get all of our resources hosted on your site for free. So, we'll make sure you get a link in your e-mail, but reach out to us with any questions as well if you would like to do that.

So, we're looking forward to a really productive American Heart Month. So, visit our social media channels for more updates, and keep us posted on what you're planning. And I think April's gonna share some, a couple highlights from AHA as well.

April Wallace: Thank you, Robin. Yes, so AHA has planned a month of activities to celebrate American Heart Month, and they're highlighted here on the slide, and many of these will be heavily promoted through our social media channels as well. So, just to kind of highlight, February 2nd is our National Wear Red Day, and on social media, we'll be using the official hashtag, it's #wearredday.

Then, on February 6th, there's Woman's Day Red Dress Awards, which specifically—it honor those who have made significant contributions to the fight against heart disease. And so, there's gonna be a huge gala, and there's gonna be—it's gonna be hosted by some very famous people, including Grammy Award winner Melissa Etheridge, who's gonna be headlining the event.

Then, February 7th through the 14th, it's Congenital Heart Defect Week, and this is a national awareness week to raise awareness about CHD and recognize the families and patients.

February 11th through the 17th will be our Heart Failure Awareness Week, and then February 22nd will be the Heart Valve Disease Day.

And just a special note, and just in conjunction with what Robin mentioned earlier about the Ground Rounds that's coming up on February 20th—we will also be hosting a viewing party for the Grand Rounds here in Washington, D.C. at the Federal Advocacy Office for the American Heart Association. If you are interested in attending that viewing party, please feel free to reach out to me at april.wallace@heart.org, and I can send you more information. As well, if you'd like to host your own viewing party, we'd love to have you join and have your networks join in the office or wherever to participate in this activity as well. So, I can send you more information about how you can actually set up your own viewing party wherever you're located.

Again, thank you, all, for joining today. I would like to thank our presenters—Dr. Wright, Dr. Letitia Presley-Cantrell, Heather Hodge, and Dani Pere—for all being a part of today's call. Again, if you have questions, and especially those that were not answered during the call, please keep sending those questions in and we'll make sure that we triage those to the appropriate presenter, and we'll get those answered for you.

Also, following today's call, you'll receive notification once the transcripts are available for this call.

Our next call is gonna be scheduled for April 17th, 2018 at 1 p.m. Eastern time, and so, we look forward to you joining us again on April 17th. And that's all we have for today. Thank you, all, for joining, and we will talk with you soon.

[End of Audio]