“Advancing Million Hearts®:
AHA and State Heart Disease and Stroke Prevention
Programs Working Together in Rhode Island”

August 9, 2016

Founders Affiliate: Providence, Rhode Island

Contents include:

   Agenda
   Attendees
   Discussion Notes
   Pre-evaluation
   Slide Deck
   Meeting Handouts
   Post-evaluation
“Advancing Million Hearts®:  
AHA and State Heart Disease and Stroke Prevention  
Programs Working Together in Rhode Island”  
August 9, 2016

This event was presented by the Million Hearts® Collaboration, co-chaired by the American Heart Association and the National Forum for Heart Disease and Stroke Prevention. Funding for this event is made possible (in part) by the Centers for Disease Control and Prevention for the Million Hearts® Collaboration.

Those invited to attend included colleagues from the American Heart Association, Rhode Island Department of Health, health systems, health insurers, and professional associations.

**Meeting Purpose:**  
Connecting staff from AHA Affiliates, state health departments and other state and local heart disease and stroke prevention partners to establish and engage in meaningful relationships around Million Hearts® efforts.

**Meeting Objectives:**  
At the end of the meeting, participants will be able to:  
1) Identify Million Hearts focused activities for 2016  
2) Recognize Million Hearts® evidence-based and practice-based CVD prevention strategies and approaches  
3) List partner programs and resources that align with Million Hearts  
4) Identify programs efforts that align and ways to work together  
5) Create plan for follow-up to increase engagement  
6) Recognize key contacts within heart disease and stroke prevention

**Rhode Island Focus:** Partner meeting, sharing, connecting

**Registrants:** 42

**Evaluation Highlights:**  
**The most valuable part of the meeting was:**  
- Opportunity to hear about current activities and resources available  
  - Best practices  
  - Partner sharing and aligning programs  
- Networking  
- Sharing resources with one another

**Ways to improve in the future:**  
- Identify ways community based organizations can connect with clinical practices  
- Concrete examples of how to implement best practices
Brainstorming Session Notes

- **High level overview of the key areas recognized for collaboration**
  - Community Health Network
  - Community Health Workers/certification program
  - Healthy Food Procurement/Nutrition
  - Health Equity Zones
  - Smoking Cessation, Tobacco 21
  - Self Measured Blood Pressure (SMBP)
  - State Innovation Model (SIM)
  - WISEWOMEN

- **Next steps over these next few months**
  - Identify additional partners
  - Discuss how to keep momentum going
  - Sub groups? Calls with stakeholders?

- **Content to share with the participants**
  - CHW certification program
  - How to promote and use the Community Health Network
  - SIM work
  - Share information through HealthCentric e-newsletter for providers
  - Resources from Thundermist- quiz on proper BP, smoking cessation resources, farmers market, cooking classes, yoga

- **Summary of the resources they need / compiled**
  - AHA Resources were shared by Nikki through email
Facilitated Discussion/Flip Chart Notes:

### Strategy: Identify Undiagnosed Hypertension

<table>
<thead>
<tr>
<th>Collaboration</th>
<th>Partner</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plans</td>
<td>THC, HCA working with WDD to facilitate, HCA facilitate with faith-based organizations; barbers/hairstylists</td>
<td>Collaborate on community BP checks [Michelle Barron-Magee – RI Dept. of Health]</td>
</tr>
<tr>
<td></td>
<td>Laura Jones – RIPIN</td>
<td>ER Diversion</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:Nikki.Burnett@heart.org">Nikki.Burnett@heart.org</a></td>
<td>Wise Women – health coaching</td>
</tr>
</tbody>
</table>

#### Collaboration
- Health Plans
- THC
- HCA working with WDD to facilitate
- HCA facilitate with faith-based organizations; barbers/hairdressers
- HEZ RI Dept. of Health help connect

#### Partner
- Laura Jones – RIPIN
- Nikki.Burnett@heart.org

#### Activity
- Empowered to SERVE
  - Faith-Based
  - Housing
  - Collegic
  - Strategic Alliances

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### Strategy: Address Uncontrolled Hypertension

<table>
<thead>
<tr>
<th>Collaboration</th>
<th>Partner</th>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td>Health Plans</td>
<td>THC</td>
<td>WISE Women</td>
</tr>
<tr>
<td>Community Health Workers</td>
<td>Host WISE Women table at farmers’ market Aug. 17 (Cindy Singleton – Westbay Community Action)</td>
<td></td>
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<tr>
<td>Community Pharmacists</td>
<td>RIPIN Community Health Workers</td>
<td>Medication Adherence</td>
</tr>
<tr>
<td>Community Health Workers</td>
<td>THC</td>
<td>Patient Education</td>
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</table>

#### Collaboration
- Health Plans
- Community Health Workers
- Community Pharmacists
- Smoke-Free Housing (Benvinda RI Dept. of Health)

#### Partner
- THC
- HCA
- SIM
- Community Pharmacists
- Community Health Workers
- RPI Community Health Workers
- RI Dept. of Health

#### Activity
- Empowered to SERVE
  - Faith-Based
  - Housing
  - Collegic
  - Strategic Alliances
<table>
<thead>
<tr>
<th>Collaboration</th>
<th>Partner</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>- HCA have many resources and tools available</td>
<td>- <a href="mailto:Nikki.Burnett@heart.org">Nikki.Burnett@heart.org</a></td>
<td>Provider Education</td>
</tr>
<tr>
<td>- HCA podcasts, webinar, and e-newsletter - Nikki Burnett – American Heart Association</td>
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</table>

**Other ABCS Strategies**

<table>
<thead>
<tr>
<th>Collaboration</th>
<th>Partner</th>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td>- Megan Tucker – AHA - Nikki Burnett – AHA</td>
<td></td>
<td>Policy change for sugar reduction</td>
</tr>
<tr>
<td>- RI Dept. of Health Tobacco Control - Megan Tucker – AHA</td>
<td></td>
<td>Tobacco 21</td>
</tr>
<tr>
<td>Incorporate low sodium Million Hearts® recipes into veggie bakes (Cindy – Westbay)</td>
<td>Incorporate Healthy Workplace Food &amp; Beverage Toolkit to workplace (Cindy – Westbay)</td>
<td>Workplace Healthy Eating Program</td>
</tr>
<tr>
<td>Host healthy food instruction from partner agency at our work wellness event (Cindy – Westbay)</td>
<td>- THC (currently participating) - Megan Tucker – AHA - Nikki Burnett – AHA</td>
<td>Healthy Food Access</td>
</tr>
<tr>
<td></td>
<td>RI Dept. of Health Tobacco Control</td>
<td>- Community Health Network - CHW Role in Community (sustainability/define)</td>
</tr>
<tr>
<td>K. Hastings – Nursing, Pharmacists</td>
<td>- RI Dept. of Health Tobacco Control - Nikki Burnett – AHA</td>
<td>Health Equity Zone</td>
</tr>
<tr>
<td>RIPIN Health Plans</td>
<td>- Communities of Care RIPIN - Communicate ER Diversion in our client case management (Cindy – Westbay)</td>
<td>Community of Care</td>
</tr>
<tr>
<td>K. Hastings – Nursing, Pharmacists</td>
<td>- RI Dept. of Health Tobacco Control - Help to ban tobacco in our supportive housing - Megan Tucker – AHA - RI Dept. of Health Tobacco Control</td>
<td>Tobacco bans in public housing Tobacco-Free Youth</td>
</tr>
<tr>
<td></td>
<td>RI Dept. of Health Tobacco Control</td>
<td>Reducing Tobacco Retailers</td>
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</table>
Other ABCS Strategies (cont.)

<table>
<thead>
<tr>
<th>Activities</th>
<th>Partners</th>
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<tbody>
<tr>
<td>Community Health Network</td>
<td><a href="mailto:Nikki.Burnett@heart.org">Nikki.Burnett@heart.org</a>, RI Dept. of Health Tobacco Control, Smoke-Free Housing (Benvinda RIDOH)</td>
</tr>
<tr>
<td>Education for patients for proper blood pressure measuring</td>
<td>Need partner to perform blood pressure checks at farmers’ markets, K. Hastings – Nursing, Pharmacists, Qualidegree blood pressure measuring, HCA creating collateral materials</td>
</tr>
<tr>
<td>Farmers’ Market (vouchers)</td>
<td>THC currently participating</td>
</tr>
<tr>
<td>Cooking classes</td>
<td>HCA – ? facilitate collaboration with J&amp;W or Wingate, THC currently doing, EBCAP (wants info), RIDOH ? offer to health equity zones and raise awareness of nutrition in community/environment, HCA willing to collaborate</td>
</tr>
<tr>
<td>Yoga</td>
<td>THC currently doing, EBCAP (wants info)</td>
</tr>
<tr>
<td>Engage Restaurant Association</td>
<td>Suggested intervention</td>
</tr>
<tr>
<td>ABCS of Taking Blood Pressure</td>
<td>AHA document – <a href="mailto:Nikki.Burnett@heart.org">Nikki.Burnett@heart.org</a></td>
</tr>
<tr>
<td>Simple Cooking with Heart</td>
<td>AHA</td>
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<tr>
<td>Food and Beverage Toolkit</td>
<td>AHA</td>
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<tr>
<td>Access to Cessation Services</td>
<td>Smoke-Free Housing (Benvinda RIDOH), RI Dept. of Health Tobacco Control, Advertise smoke-free message in senior and employee newsletters (Cindy -- Westbay), THC, RI Dept. of Health Tobacco Treatment Specialist Network</td>
</tr>
<tr>
<td>Activities</td>
<td>Partners</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Connect to community partners for tobacco-cessation – seeking partners statewide and FQHCs</td>
<td>RI Dept. of Health Tobacco Control Program</td>
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<tr>
<td>Smoke-free campuses</td>
<td>- RI Dept. of Health Tobacco Control Program</td>
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<tr>
<td>- Nikki Burnett – AHA</td>
<td></td>
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<tr>
<td>Communication/messaging for tobacco cessation/smoke-free resources (Engagement tools and other collateral)</td>
<td>- RI Dept. of Health Tobacco Control Program</td>
</tr>
<tr>
<td>- Offer smoke cessation as a work wellness activity (Cindy -- Westbay )</td>
<td></td>
</tr>
<tr>
<td>Youth prevention/healthy living initiatives</td>
<td>- Youth Advocacy – Megan Tucker, AHA</td>
</tr>
<tr>
<td>- Healthy Lifestyles Program – RI Dept. of Health/RIPIN</td>
<td>- Nikki Burnett – AHA</td>
</tr>
<tr>
<td>Diabetes education</td>
<td>THC</td>
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<tr>
<td>Practice transformation</td>
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<tr>
<td>Provider competency – blood pressure check</td>
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### Additional Notes

#### Key Areas

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<tr>
<th>Who, What, When</th>
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<tbody>
<tr>
<td>SMBP</td>
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<tr>
<td>- Align programs, integrate in practicesIraqi, AHA, Thundermist</td>
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<tr>
<td>- Improve self-reporting</td>
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<tr>
<td>Health Equity Zone</td>
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<tr>
<td>- Healthier eating/cooking classes</td>
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<tr>
<td>- RI Dept. of Health, Westbay Community Action</td>
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<tr>
<td>- Hire CHW – deliver chronic disease programs</td>
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<tr>
<td>- Certify CHWs - $100 every 2 years</td>
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<tr>
<td>Community Health Workers</td>
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<tr>
<td>- Patient outreach/follow up</td>
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<td>- Determine barriers – patient navigator</td>
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<tr>
<td>- Healthcentric – share CHW info in newsletter</td>
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<tr>
<td>Nutrition</td>
</tr>
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<td>- Work wellness program</td>
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<tr>
<td>- Request for speakers</td>
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<tr>
<td>- Adelaide – Wise Women</td>
</tr>
<tr>
<td>- Jen Olsen – connect Cindy to training</td>
</tr>
<tr>
<td>- RI Dietitian Association</td>
</tr>
<tr>
<td>- AHA Resources – Food &amp; Beverage Toolkit (Nikki will send)</td>
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<tr>
<td>CHW Certification Criteria:</td>
</tr>
<tr>
<td>- Supervised work hours</td>
</tr>
<tr>
<td>- Domain training hours/proof</td>
</tr>
<tr>
<td>- On-the-job hours</td>
</tr>
<tr>
<td>- No specific curricula</td>
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</tbody>
</table>
- RI College – working on reorganization of CHW Association (navigate application process)
Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in Rhode Island
August 10, 2016

Contact List

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization/Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valentina Adamova</td>
<td>Health Program Administrator</td>
<td>Rhode Island Department of Health</td>
</tr>
<tr>
<td>Ckarla Agudelo</td>
<td>WOON HEZ Program Manager</td>
<td>Thundermist Health Center</td>
</tr>
<tr>
<td>Victor Arias</td>
<td>Health Equity Zone Program Manager</td>
<td>Thundermist Health Center</td>
</tr>
<tr>
<td>Lanette Baker</td>
<td>Senior Public Health Promotion Specialist</td>
<td>Rhode Island Department of Health</td>
</tr>
<tr>
<td>Michelle Barron-Magee</td>
<td>Collaborative Network Coordinator</td>
<td>Rhode Island Department of Health</td>
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<tr>
<td>Lisa Bemben</td>
<td>Reg. Dir. Quality Systems Improvement</td>
<td>American Heart Association</td>
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<tr>
<td>Erin Boles Welsh</td>
<td>Tobacco Control Program Manager</td>
<td>Rhode Island Department of Health</td>
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<tr>
<td>David Bourassa, MD</td>
<td>Chief Medical Director</td>
<td>Thundermist Health Center</td>
</tr>
<tr>
<td>Adriane Burke</td>
<td>Health Systems Coordinator</td>
<td>NH Division of Public Health Services</td>
</tr>
<tr>
<td>Nikki Burnett</td>
<td>Regional VP, Multicultural Initiatives</td>
<td>American Heart Association</td>
</tr>
<tr>
<td>Samantha Clarke</td>
<td>Marketing &amp; Member Engagement Director</td>
<td>Newport County YMCA</td>
</tr>
<tr>
<td>Bonnie Cooper</td>
<td>RN Manager</td>
<td>Wood River Health Services</td>
</tr>
<tr>
<td>David Day</td>
<td>VP Government Relations</td>
<td>AHA-Founders Affiliate</td>
</tr>
<tr>
<td>Dora Dumont</td>
<td>Epidemiologist</td>
<td>Rhode Island Department of Health</td>
</tr>
<tr>
<td>Name</td>
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<tr>
<td>Mary Evans</td>
<td>Chief Operating Officer</td>
<td>Rhode Island Health Center Association</td>
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<td>Jasmine Franco</td>
<td>Arthritis Program Manager</td>
<td>Rhode Island Department of Health</td>
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<tr>
<td>Mary Jo Garofoli</td>
<td>Interim Operations Analyst</td>
<td>National Forum for Heart Disease &amp; Stroke Prevention</td>
</tr>
<tr>
<td>Elise George</td>
<td>Program Evaluator</td>
<td>Rhode Island Department of Health</td>
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<tr>
<td>Julie Harvill</td>
<td>Operations Manager, Million Hearts Collaboration</td>
<td>American Heart Association</td>
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<tr>
<td>Kristine Hastings</td>
<td>Quality Assurance Manager</td>
<td>Nursing Placement, Inc</td>
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<tr>
<td>Brenda Jenkins</td>
<td>Senior Program Administrator</td>
<td>Healthcentric Advisors</td>
</tr>
<tr>
<td>Laura Jones</td>
<td>Director of Health Programs</td>
<td>Rhode Island Parent Information Network</td>
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<tr>
<td>Michelle Karn</td>
<td></td>
<td>American Heart Association</td>
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<tr>
<td>Michele Kelvey-Albert</td>
<td>Director of consulting services</td>
<td>Qualidigm</td>
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<tr>
<td>Adelaide Lafferty Ritt</td>
<td>Wisewoman QI Coordinator</td>
<td>Rhode Island Department of Health</td>
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<tr>
<td>Angela Lemire</td>
<td>Communications Coordinator, Tobacco Control</td>
<td>Rhode Island Department of Health</td>
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<tr>
<td>Judith Logan</td>
<td>Director of Nursing</td>
<td>Thundermist Health Center</td>
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<tr>
<td>Dana McCants Derisier</td>
<td>Tobacco Control Program Coordinator</td>
<td>Rhode Island Department of Health</td>
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<tr>
<td>Jennifer Mello</td>
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<td>East Bay Community Action</td>
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<tr>
<td>Sandra Mota</td>
<td>Nurse Care Manager</td>
<td>Nardone Medical Associates</td>
</tr>
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<tr>
<td>Jennifer Olsen</td>
<td>Health Systems Coordinator</td>
<td>Rhode Island Department of Health</td>
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<td>Armstrong</td>
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<tr>
<td>Miriam Patanian</td>
<td>Lead Consultant for Cardiovascular Health</td>
<td>National Association of Chronic Disease Directors</td>
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<tr>
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<td>and Heal</td>
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<tr>
<td>Angela Reda</td>
<td>Clinical Nurse Manager</td>
<td>Tri-Town Community Action Agency</td>
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<td>Robin Rinker</td>
<td>Health Communications Specialist</td>
<td>Centers for Disease Control and Prevention</td>
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<td>Benvinda Santos</td>
<td>Community Coordinator</td>
<td>Rhode Island Department of Health</td>
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<tr>
<td>Julia Schneider</td>
<td>Consultant, CVH Team</td>
<td>National Association of Chronic Disease Directors</td>
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<td>Cindy Singleton</td>
<td>Director of Family Services</td>
<td>Westbay Community Action</td>
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<tr>
<td>Rose Stamilio</td>
<td>Care Coordinator</td>
<td>Qualidigm</td>
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<tr>
<td>Nancy Sutton</td>
<td>Acting Center Lead, CCDM</td>
<td>Rhode Island Department of Health</td>
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<tr>
<td>Neta Taylor</td>
<td>VP Health Living &amp; Membership</td>
<td>YMCA of Greater Providence</td>
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<td>Lois Teitz</td>
<td>Director of Quality</td>
<td>Comprehensive Community Action Program</td>
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<tr>
<td>Erin Thomas</td>
<td>Nurse Care Manager</td>
<td>East Bay Community Action Program (EBCAP)</td>
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<td>Megan Tucker</td>
<td>Director of Government Relations</td>
<td>American Heart Association</td>
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<tr>
<td>Georgette Verhelle</td>
<td>QI Project Coordinator</td>
<td>New England QIN-QIO/Qualidigm</td>
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<tr>
<td>April Wallace</td>
<td>Program Initiatives Manager</td>
<td>American Heart Association</td>
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</table>
Advancing Million Hearts®:
AHA and Heart Disease and Stroke Prevention Partners Working Together in Rhode Island

AUGUST 9, 2016
10:00 AM - 3:00 PM ET

Healthcentric Advisors
235 Promenade St., Suite 500
Providence, Rhode Island 02908
MEETING PURPOSE:
Connecting staff from the American Heart Association (AHA) Affiliates, state health departments and other state and local heart disease and stroke prevention partners to establish and engage in meaningful relationships around Million Hearts® efforts.

MEETING OBJECTIVES:
At the end of the meeting, participants will be able to:
- Identify Million Hearts® focused activities for 2016
- Recognize Million Hearts® evidence-based and practice-based CVD prevention strategies and approaches
- List partner programs and resources that align with Million Hearts®
- Identify programs efforts that align and ways to work together
- Create plan for follow-up to increase engagement
- Recognize key contacts within heart disease and stroke prevention

MEETING OUTCOMES:
Attendees will have expanded their knowledge of evidence based programs, collaboration strategies, tools, resources and connections to align programs and new initiatives that support Million Hearts®.
AGENDA

10:00 AM  WELCOME, OVERVIEW OF THE DAY, AND INTRODUCTIONS
Brenda Jenkins, RN, D.Ay., CDOE, CPEHR, PCMH CCE
Senior Program Administrator / HIT Consultant
Healthcentric Advisors

What excites you about your role in heart disease and stroke prevention?

10:20 AM  RECOGNITION OF MILLION HEARTS® HYPERTENSION CHAMPION:
THUNDERMIST HEALTH CENTER
Jennifer Olsen-Armstrong, MS, RD
Health System Coordinator
Chronic Care & Disease Management Team
Rhode Island Department of Health

David Bourassa, MD
Chief Medical Director at Thundermist Health Center

10:30 AM  PATIENT STORIES
Shantha Diaz
Chief Operating Officer, Neighborhood Health Plan of Rhode Island

10:50 AM  MILLION HEARTS®
Robin Rinker, MPH, CHES, Health Communications Specialist
Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention

- Overview of Million Hearts®
- Million Hearts® accomplishments
- What must happen to prevent
- 2016 Focus

Q & A
11:20 AM  RHODE ISLAND PROGRAMS THAT ALIGN WITH MILLION HEARTS®  
Jennifer Olsen-Armstrong, MS, RD  
Q & A

11:30 AM  HEALTHCENTRIC ADVISORS  
Brenda Jenkins  
Q & A

11:40 AM  AMERICAN HEART ASSOCIATION PROGRAMS AND RESOURCES THAT ALIGN WITH MILLION HEARTS®  
Megan Tucker, Director of Government Relations  
Nicki Burnett, Regional VP, Multicultural Initiatives  
Q & A

12:00 PM  CATERED LUNCH

12:30 PM  PARTNER SHARING, PROGRAMS AND PERSONS THAT ALIGN, WAYS TO WORK TOGETHER AND NEXT INTERACTIONS  
Miriam Patanian, MPH and Julia Schneider, MPH  
Public Health Consultants  
Cardiovascular Health Team  
National Association of Chronic Disease Directors

2:45 PM  WRAP UP/ADJOURN  
April D. Wallace, MHA, Program Initiatives Manager  
The Million Hearts® Collaboration, American Heart Association

REGISTRANTS AS OF AUGUST 3, 2016  
**Q1 How familiar are you with the Million Hearts® Initiative key components?**

Key components include: A focus on the ABCs (address aspirin when appropriate, blood pressure control, cholesterol management, smoking cessation, sodium reduction and eliminating transfat intake) through changing the environment and optimizing care 

**Health Information Technology Innovations in Care delivery**

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![Bar Chart](chart.png)

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
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<tr>
<td>Not familiar</td>
<td>22.22%</td>
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<tr>
<td>Somewhat familiar</td>
<td>55.56%</td>
</tr>
<tr>
<td>Very familiar</td>
<td>22.22%</td>
</tr>
<tr>
<td>Highly familiar</td>
<td>0.00%</td>
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Total: 9
Q2 Are there any of the key components you would like to expand upon?

Answered: 2  Skipped: 7

<table>
<thead>
<tr>
<th>#</th>
<th>Responses</th>
<th>Date</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Motivational interviewing</td>
<td>8/3/2016 5:39 PM</td>
</tr>
<tr>
<td>2</td>
<td>BP control, sodium reduction, food and beverage guidelines which includes vending and procurement</td>
<td>8/1/2016 8:17 AM</td>
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</tbody>
</table>
Q3 Of the Million Hearts® key components, what are you most interested in learning more about?

Answered: 9    Skipped: 0

Answer Choices

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
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<tbody>
<tr>
<td>A focus on the ABCs (address aspirin when appropriate, blood pressure control, cholesterol management, smoking cessation, sodium reduction and eliminating transfat intake) through changing the environment and optimizing care</td>
<td>44.44% 4</td>
</tr>
<tr>
<td>Health Information Technology</td>
<td>11.11% 1</td>
</tr>
<tr>
<td>Innovations in Care delivery</td>
<td>44.44% 4</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>0.00% 0</td>
</tr>
</tbody>
</table>

Total 9

#    Other (please specify)                      Date

There are no responses.
Q4 What has been your primary action in Million Hearts® to date, if any?

Answered: 3  Skipped: 6

<table>
<thead>
<tr>
<th>#</th>
<th>Responses</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identifying at risk patients via patient registry and employing strategies to reduce risk.</td>
<td>8/4/2016 11:11 AM</td>
</tr>
<tr>
<td>2</td>
<td>Peripherally involved with Rhode Island Chronic Care Collaborative. have used the Million Hearts model to educate patients/staff on proper positioning for SMBP.</td>
<td>8/1/2016 11:51 AM</td>
</tr>
<tr>
<td>3</td>
<td>My organization (AHA/ASA) has been mostly involved through our advocacy efforts</td>
<td>8/1/2016 8:17 AM</td>
</tr>
</tbody>
</table>
Q5 What organizations or partners do you work with outside of your agency to address heart disease and stroke prevention?

Answered: 6  Skipped: 3

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner 1</td>
<td>100.00%</td>
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<tr>
<td>Partner 2</td>
<td>66.67%</td>
</tr>
<tr>
<td>Partner 3</td>
<td>50.00%</td>
</tr>
<tr>
<td>Partner 4</td>
<td>16.67%</td>
</tr>
<tr>
<td>Partner 5</td>
<td>0.00%</td>
</tr>
<tr>
<td>Partner 6</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Partner 1</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RIDOH</td>
<td>8/4/2016 11:11 AM</td>
</tr>
<tr>
<td>2</td>
<td>QIO</td>
<td>8/4/2016 7:35 AM</td>
</tr>
<tr>
<td>3</td>
<td>Ri's Federally Qualified Health Centers</td>
<td>8/2/2016 3:04 PM</td>
</tr>
<tr>
<td>4</td>
<td>Rhode island Chronic Care Collaborative (RICCC)</td>
<td>8/1/2016 11:51 AM</td>
</tr>
<tr>
<td>5</td>
<td>Neighborhood Health Plan of RI</td>
<td>8/1/2016 8:17 AM</td>
</tr>
<tr>
<td>6</td>
<td>American Heart Association</td>
<td>8/1/2016 7:32 AM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Partner 2</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RICCC</td>
<td>8/4/2016 11:11 AM</td>
</tr>
<tr>
<td>2</td>
<td>contractors</td>
<td>8/4/2016 7:35 AM</td>
</tr>
<tr>
<td>3</td>
<td>RI Multicultural Leadership Committee</td>
<td>8/1/2016 8:17 AM</td>
</tr>
<tr>
<td>4</td>
<td>Newport Hospital</td>
<td>8/1/2016 7:32 AM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Partner 3</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>FOHC's/RHC</td>
<td>8/4/2016 7:35 AM</td>
</tr>
<tr>
<td>2</td>
<td>Wiggins Village</td>
<td>8/1/2016 8:17 AM</td>
</tr>
<tr>
<td>3</td>
<td>Rhode Island Blood Center</td>
<td>8/1/2016 7:32 AM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Partner 4</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Area churches</td>
<td>8/1/2016 8:17 AM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Partner 5</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There are no responses.</td>
<td>8/1/2016 8:17 AM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Partner 6</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There are no responses.</td>
<td>8/1/2016 8:17 AM</td>
</tr>
</tbody>
</table>
**Q6 Are there new partners you would like to engage with?**

Answered: 2  Skipped: 7

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner 1</td>
<td>100.00%</td>
</tr>
<tr>
<td>Partner 2</td>
<td>50.00%</td>
</tr>
<tr>
<td>Partner 3</td>
<td>50.00%</td>
</tr>
<tr>
<td>Partner 4</td>
<td>50.00%</td>
</tr>
<tr>
<td>Partner 5</td>
<td>50.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Partner 1</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>more engagement with QIO</td>
<td>8/4/2016 7:35 AM</td>
</tr>
<tr>
<td>2</td>
<td>Area churches</td>
<td>8/1/2016 8:17 AM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Partner 2</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Companies through workplace wellness</td>
<td>8/1/2016 8:17 AM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Partner 3</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Housing</td>
<td>8/1/2016 8:17 AM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Partner 4</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Colleges</td>
<td>8/1/2016 8:17 AM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Partner 5</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sororities and fraternities</td>
<td>8/1/2016 8:17 AM</td>
</tr>
</tbody>
</table>
### Q7 What is your primary role/function within your organization?

Answered: 7  Skipped: 2

<table>
<thead>
<tr>
<th>#</th>
<th>Responses</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Director of Nursing</td>
<td>8/4/2016 11:11 AM</td>
</tr>
<tr>
<td>2</td>
<td>Hypertension quality improvement</td>
<td>8/4/2016 7:35 AM</td>
</tr>
<tr>
<td>3</td>
<td>Nurse Manager</td>
<td>8/3/2016 5:39 PM</td>
</tr>
<tr>
<td>4</td>
<td>COO</td>
<td>8/2/2016 3:04 PM</td>
</tr>
<tr>
<td>5</td>
<td>Clinical Nurse Manager</td>
<td>8/1/2016 11:51 AM</td>
</tr>
<tr>
<td>6</td>
<td>Regional Vice President, Multicultural Initiatives for the New England States</td>
<td>8/1/2016 8:17 AM</td>
</tr>
<tr>
<td>7</td>
<td>Senior Director, Marketing &amp; Member Engagement</td>
<td>8/1/2016 7:32 AM</td>
</tr>
</tbody>
</table>
**Q8 What are your expectations for attending the meeting?**

Answered: 7  Skipped: 2

<table>
<thead>
<tr>
<th>#</th>
<th>Responses</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Learn from other participants. Networking.</td>
<td>8/4/2016 11:11 AM</td>
</tr>
<tr>
<td>2</td>
<td>partnerships and learning what others are doing</td>
<td>8/4/2016 7:35 AM</td>
</tr>
<tr>
<td>3</td>
<td>Motivational interviewing</td>
<td>8/3/2016 5:39 PM</td>
</tr>
<tr>
<td>4</td>
<td>An increased familiarity with Million Hearts, it's goals &amp; objectives, and how those will take shape in RI</td>
<td>8/2/2016 3:04 PM</td>
</tr>
<tr>
<td>5</td>
<td>Hearing what has worked for other practices.</td>
<td>8/1/2016 11:51 AM</td>
</tr>
<tr>
<td>6</td>
<td>Networking, planning, information</td>
<td>8/1/2016 8:17 AM</td>
</tr>
<tr>
<td>7</td>
<td>Learn more about Health Promotion for the Newport County Community</td>
<td>8/1/2016 7:32 AM</td>
</tr>
</tbody>
</table>
**Q9 What does success look like at the end of the meeting?**

Answered: 5  Skipped: 4

<table>
<thead>
<tr>
<th>#</th>
<th>Responses</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Obtaining takeaways that can be utilized in our practice.</td>
<td>8/4/2016 11:11 AM</td>
</tr>
<tr>
<td>2</td>
<td>a better understanding of implementation efforts around hypertension QI</td>
<td>8/4/2016 7:35 AM</td>
</tr>
<tr>
<td>3</td>
<td>Helping at risk pts understand risks/need for life changes</td>
<td>8/3/2016 5:39 PM</td>
</tr>
<tr>
<td>4</td>
<td>See #8</td>
<td>8/2/2016 3:04 PM</td>
</tr>
<tr>
<td>5</td>
<td>Connections/plans</td>
<td>8/1/2016 8:17 AM</td>
</tr>
</tbody>
</table>
Meeting Evaluation:
Partners Working Together in Rhode Island

12 respondents completed the survey.

100% of respondents reported the meeting information was either very useful or somewhat useful in meeting the following meeting objectives.
  • Identify Million Hearts focused activities for 2016
  • Recognize Million Hearts® evidence-based and practice-based CVD prevention strategies and approaches
  • List partner programs and resources that align with Million Hearts®
  • Identify programs efforts that align and ways to work together
  • Create plan for follow-up to increase engagement
  • Recognize key contacts within heart disease and stroke prevention

The most valuable part of the meeting was:
  • Opportunity to hear about current activities and resources available (5 respondents)
    o Best practices
    o Partner sharing and aligning programs
  • Networking (3 respondents)
  • Sharing resources with one another (2 respondents)

The least valuable part of the meeting was:
  • Everything was valuable (3)
  • Physician’s input
  • Exercise at end on posters
  • The sticker, network exercise—Didn’t have a clear idea of the outcomes from next steps
  • Advertisements given by some attendees
  • Need to identify better ways to work together and plan for increasing engagement

Ways to improve in the future:
  • Bring other stakeholders to the table (3)
    o “Lovely to have community partners at the table but too many Indians not enough Chiefs. Need buy in from the Health Centers, doctors, legislatures.”
  • Extend meeting ½ and include brief breaks after sessions
  • Allow more time for communication among attends
  • Identify ways community based organizations can connect with clinical practices
  • Concrete examples of how to implement best practices
  • Have another meeting in New Hampshire
Advancing Million Hearts®:
AHA and State Heart Disease and Stroke Prevention Partners Working Together in Rhode Island

August 9, 2016
10:00 AM to 3:00 PM ET

Healthcentric Advisors
235 Promenade St., Suite 500
Providence, RI 02908
Welcome & Overview of the Day

Brenda Jenkins, RN, D.Ay., CDOE, CPEHR, PCMH CCE
Senior Program Administrator / HIT Consultant
Healthcentric Advisors
Introductions

What excites you about your role in heart disease and stroke prevention?
RECOGNITION OF MILLION HEARTS®

HYPERTENSION CHAMPION:

THUNDERMIST HEALTH CENTER

David Bourassa, MD
Chief Medical Director at Thundermist Health Center
PATIENT STORIES

Shantha Diaz
Chief Operating Officer, Neighborhood Health Plan of Rhode Island
The Million Hearts® Initiative

Advancing Million Hearts in Rhode Island

August 9, 2016

Providence, Rhode Island
Million Hearts®

Goal: Prevent 1 million heart attacks and strokes by 2017

- National initiative co-led by CDC and CMS in partnership with federal, state, and private sectors
- To address the causes of 1.5M events and 800K deaths a year, $316.6 B in annual health care costs and lost productivity and major disparities in outcomes
Key Components of Million Hearts®

Keeping Us Healthy
Changing the environment

Excelling in the ABCS
Optimizing care

Focus on the ABCS

Health tools and technology

Innovations in care delivery


## Getting to a Million by 2017: Public Health Targets

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Pre-Initiative Estimate 2009-10</th>
<th>2017 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking prevalence*</td>
<td>26%</td>
<td>24%</td>
</tr>
<tr>
<td>Sodium reduction</td>
<td>3580 mg/day</td>
<td>2900 mg/day</td>
</tr>
<tr>
<td>Trans fat reduction</td>
<td>0.6% of calories</td>
<td>0% of calories</td>
</tr>
</tbody>
</table>

* Includes all forms of combustible tobacco – cigarettes, pipes, and cigars

National Survey on Drug Use and Health, National Health and Nutrition Examination Survey
## Getting to a Million by 2017: Targets for the ABCS

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Pre-Initiative Estimate 2009-2010</th>
<th>2017 Population-wide Goal</th>
<th>2017 Clinical Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin when appropriate</td>
<td>54%</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td>Blood pressure control</td>
<td>52%</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td>Cholesterol management</td>
<td>33%</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>22%</td>
<td>65%</td>
<td>70%</td>
</tr>
</tbody>
</table>

National Ambulatory Medical Care Survey, National Health and Nutrition Examination Survey
Million Hearts® Accomplishments*

Changing the Environment

- **Reduce Smoking**
  - Almost 4 million fewer cigarette smokers†

- **Reduce Sodium Intake**
  - More than 2 billion meals/year will have reduced sodium‡
    - Draft Voluntary Guidance to Industry Released June 1, 2016

- **Eliminate Trans Fat Intake**
  - Accomplished: FDA issued the final determination on artificial trans fat§

---

* Note this is a select set of notable Million Hearts® accomplishments.
† National Health Interview Survey, comparing 2011 data to 2014 data
‡ Aramark pledge [http://blog.heart.org/aha-aramark-join-on-meals-initiative/](http://blog.heart.org/aha-aramark-join-on-meals-initiative/)
§ [http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm372915.htm#top](http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm372915.htm#top)
Million Hearts® Accomplishments

Optimizing Care in the Clinical Setting

Focus on the ABCS

Millions of Americans are covered by health care systems that are recognizing or rewarding performance in the ABCS**

Health Tools and Technology

Over half a million patients have been identified as potentially having hypertension using health IT tools††

Innovations in Care Delivery

Millions of dollars in public and private funds have been leveraged to focus on improving the ABCS‡‡

** CMS Physician Compare and HRSA Uniform Data Set
†† Unpublished data from AMGA/MUPD and NACHC HIPS project
‡‡ CMS Million Hearts Risk Reduction Model, AHRQ EvidenceNOW, AHA Southwest Affiliate HTN project
Million Hearts Progress to Date

- Engagement and activation
- Clinical Quality Measure alignment
- Understand what works, where, and why
- Resources that help
- Extraordinary support for prevention
Million Hearts®
Hypertension Control Champions

- Practices and systems achieved control rates > 70%
- Champions used evidence-based strategies
  - Hypertension treatment protocols
  - Self-measured blood pressure monitoring
  - Frequent check-in’s
  - Registries and proactive outreach
  - Team-based care.
- Next Million Hearts® Hypertension Control Challenge planned for launch in Feb 2017

59 Champions
Representing Solo to 70,000 Clinicians
Serving over 13 million people
>70% Control Rate
Standardizing Treatment through Protocols

- Hypertension Treatment Protocol
  - Use is on the Rise
    - All Indian Health Service clinical settings
    - Many Federally Qualified Health Centers
    - Practices supported by CMS’ Quality Improvement Organizations

- Tobacco Treatment Protocol
  - Released a Tobacco Treatment Protocol in May
  - Customizable templates
  - Implementation guidance - coming in July
Million Hearts® Microsite for Clinicians

- Syndicated for your website audience
- Customized for your site’s size and color pallet
- Brand it with your logo
- Content is continuously maintained by CDC

The microsite and embed code will be available at https://tools.cdc.gov/medialibrary/index.aspx#/results
What Must Happen To Prevent a Million?

**Reduce Smoking**
- 6.3M fewer smokers
  - Year-round media campaigns; pricing interventions
  - Targeted outreach to drive uptake of covered benefits
  - Systematic delivery of cessation services through use of cessation protocols, referrals to quit lines, and training of clinical staff
  - Widespread adoption of smoke-free space policies
  - Awareness of risks of second-hand smoke and the health benefits of smoke-free environments

**Control Hypertension**
- 10M more patients
  - Detection of those with undiagnosed hypertension
  - Systematic use of treatment protocols & other select QI tools
  - Practice of self-measured BP monitoring with clinical support
  - Recognition of high performers; dissemination of best practices
  - Connection of clinical & community resources to benefit people with HTN
  - Enhanced medication adherence
  - Intense focus on those with high burden and at high risk

**Decrease Sodium Intake**
- 20% reduction
  - Adoption of Healthy Food Service Guidelines
  - Voluntary sodium reduction and expansion of choices by food industry
  - Recognition of high performers and dissemination of best practices
  - Clear communication of the evidence supporting the health benefits of population-level sodium reduction

Events will also be prevented by improving aspirin use, cholesterol management, and utilization of cardiac rehab, and by eliminating artificial trans-fat consumption
Focus of 2016

• Smoking cessation
  – Facilitate implementation of tobacco cessation protocols
  – Promote smoke-free spaces

• Hypertension control
  – Facilitate use of self-measured BP monitoring, treatment protocols, and processes to find the undiagnosed
  – Share best practices by promoting action guides that identify and control hypertension

• Sodium reduction
  – Advance adoption of procurement guidelines
  – Disseminate healthy eating resources
Focus of 2016

• Cholesterol management
  – Implement statin measure across clinical settings
  – Support partner actions currently underway

• Cardiac rehab
  – Facilitate collective actions to increase referral and participation

• Embed ABCS measures in value-based models

• Capture and tell the story of your success

• Recognize high performers & share best practices
  – Learn about the successes of the Hypertension Control Champions and share their lessons learned.
3 Phase Framework for Million Hearts
January 2016-July 2017

**Primary Activities, Timelines, and Deliverables**

**Finishing Strong**
- January to December 2016
- Plant and push key actions
- Measure and report impact
- Collect and tell stories
- Celebrate

**Transition Zone**
- March 2016-July 2017
- Gather input from stakeholders
- Incorporate findings of evaluation and modeling
- Set framework, metrics, budget
- Engage partners, leadership
- Disseminate final report

**Million Hearts 2.0**
- January - July 2017 Launch
- Issue new aim and targets
- Ignite novel collaborations
- Gather powerful commitments
- Serially launch at events in 1st 6 months

Cogent Final Report

Refreshed, Bold, Engaging Initiative

Bigger, Deeper Impact
Million Hearts® Resources

- Hypertension Control: Change Package for Clinician
- Hypertension Treatment Protocols
- Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners
- Cardiovascular Health: Action Steps for Employers
- 100 Congregations for Million Hearts
- Million Hearts Healthy Eating & Lifestyle Resource Center
- Million Hearts® E-update
- Visit www.millionhearts.hhs.gov to find more resources
Thank You

Subscribe—and Contribute to the E-Update

Commit to key action steps

Work together to prevent heart attacks and strokes
Million Hearts®

Goal: Prevent 1 million heart attacks and strokes by 2017

- National initiative co-led by CDC and CMS in partnership with federal, state, and private sectors
- To address the causes of 1.5M events and 800K deaths a year, $316.6 B in annual health care costs and lost productivity and major disparities in outcomes
Q & A

Group Interaction

How does your work align with Million Hearts®?
Advancing Million Hearts in Rhode Island

RIDOH Programs

August 9, 2016

Jennifer Olsen-Armstrong, MS, RD
Chronic Care and Disease Management Team, RIDOH
Jennifer.Olsen@health.ri.gov
Million Hearts® Targets

Changing the Environment

- Reduce smoking
- Reduce sodium intake
- Eliminate trans fat intake

By 2017...

- The number of American smokers has declined from 26% to 24%
- Americans consume less than 2,900 milligrams of sodium each day
- Americans do not consume any artificial trans fat

Optimizing Care in the Clinical Setting

- Focus on the ABCS
- Use health tools and technology
- Innovate in care delivery

- Blood pressure control
- Cholesterol management
- Smoking cessation treatment

Stay Connected

http://millionhearts.hhs.gov/be_one_mh.html
facebook.com/MillionHearts
twitter.com/@MillionHeartsUS
millionhearts@cdc.gov

Million Hearts ® promotes clinical and population-wide targets for the ABCS. The 70% values shown here are clinical targets for people engaged in the health care system. For the U.S. population as a whole, the target is 65% for the ABCS.
1 in 3 RI Adults has High Blood Pressure

Estimated # of RI adults with hypertension: 281,300

In the U.S.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of hypertension</td>
<td>29.0%</td>
</tr>
<tr>
<td>% uncontrolled</td>
<td>53.5%</td>
</tr>
<tr>
<td>Of the uncontrolled, % unaware of having hypertension</td>
<td>40.0%</td>
</tr>
</tbody>
</table>
Rhode Island Chronic Care Collaborative

- 14 Practices
  - Federally Qualified Health Centers
  - Hospital Based Clinic
  - Free Clinic

- Work includes
  - Review data
  - Plan-Do-Study Act cycles
  - Network/ share
  - Submit progress reports
Rhode Island Chronic Care Collaborative

- Hypertension Control is a Priority
- Accurate Blood Pressure Measurement
- Evidence-based guidelines and protocols
- Facilitate Patient Self-Management
  - Goal Setting, Self-Measured Blood Pressure
- Team Based Care
- Technology
  - EMR assessment/ workflow analysis
Accurate Measurement

Are you ready for your big wedding?

Not really, there's so much to do— I am very nervous these days.
### Accurate Measurement

<table>
<thead>
<tr>
<th>Possible effect on systolic blood pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cuff too small</strong>*</td>
</tr>
<tr>
<td>*Most Frequent Error is wrong cuff size, especially too small</td>
</tr>
<tr>
<td>**Cuff too large *</td>
</tr>
<tr>
<td><strong>Cuff placed over clothing</strong></td>
</tr>
<tr>
<td><strong>Arm above heart level</strong></td>
</tr>
<tr>
<td><strong>Arm below heart level</strong></td>
</tr>
<tr>
<td><strong>Feet not flat on floor</strong></td>
</tr>
<tr>
<td><strong>Back not supported</strong></td>
</tr>
<tr>
<td><strong>Legs crossed</strong></td>
</tr>
<tr>
<td><strong>Patient doesn’t rest 5 minutes before</strong></td>
</tr>
<tr>
<td><strong>Patient talking</strong></td>
</tr>
<tr>
<td><strong>Full bladder</strong></td>
</tr>
<tr>
<td><strong>Tobacco or Caffeine Use</strong></td>
</tr>
</tbody>
</table>

Self-Measured Blood Pressure

- 5 RICCC practices focus on SMBP:
  - Provide BP monitor
    - Developed written agreements
  - Teach patient how to SMBP
    - Utilize AMA checklists
  - Provide Instruction on how to follow up
    - Frequency to take measurements
  - Record & utilize home measurements
Identify and develop a system to follow up with:

- Patients: \( \geq 2 \) blood pressure readings \( \geq 140 \) mmHg and/or \( \geq 90 \) mmHg
  - 2 separate visits, including the most recent
- No diagnosis of hypertension

<table>
<thead>
<tr>
<th>Definition</th>
<th>Percent of patients who do not have a diagnosis of hypertension with two or more blood pressure readings ( \geq 140 ) mmHg SBP and/or ( \geq 90 ) mmHg DBP.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Patients in the denominator who have systolic blood pressure ( \geq 140 ) mmHg and/or diastolic blood pressure ( \geq 90 ) mmHg at two separate medical visits, including the most recent visit, during the past 12 months.</td>
</tr>
<tr>
<td>Denominator</td>
<td>Active patients* age 18-85 years old who do not have a diagnosis of hypertension and were seen during the last 12 months.</td>
</tr>
</tbody>
</table>
| Exclusions | Patients less than 18 years of age
  - Patients diagnosed with Hypertension (ICD-9: 401.xx; ICD-10 codes: I10)
  - ESRD: ICD-9 code: 585.6x; ICD-10 code: N18.6 |
Well-Integrated Screening and Evaluation for WOMen Across the Nation

- CDC Funded Program
- Additional services for WCSP
  - Screenings, medical evaluation, health coaching, lifestyle programs
• Group visits for hypertension, diabetes, or CVD
• TEAMWorks Health Care Provider office
  – Provider (MD, PA, NP)
    • group presentation, and one-on-one with patient, if applicable
  – TEAMWorks pharmacist
    • individual assessment
  – TeamWorks dietitian
    • meets with each patient
Web-based Training Opportunities

Chronic Care and Disease Management Program Presents:
The Importance of Measuring Blood Pressure Accurately

Chronic Care and Disease Management Program Presents:
Taking Action on Hypertension Control—Implementing the Million Hearts HTN Control Change Package

Chronic Care and Disease Management Program Presents:
Protocols for Diagnosing Hypertension

Chronic Care and Disease Management Program Presents:
Quality Improvement: How to Overcome Barriers
Community Health Workers

• Training on Hypertension & Diabetes

• Initial focus is on CHW’s who work with health care practices
• Community Health Workers will:
  • Support patients with high blood pressure/ diabetes
  • Refer patients to community resources
Coordinate Cessation Services

- Smokers’ Quitline 1-800-QUIT-NOW
- QuitWorks – Provider Based Referral System
- Community Health Network: Centralized Referral System
- Statewide Community Based Program for Uninsured

HARD, YES. IMPOSSIBLE, NO.

QuitNowRI.com
1-800-QUIT-NOW
(1-800-784-8669)

QUITWORKS-RI
- Referring patients to free tobacco cessation services is fast and easy by fax or online.
- Get free follow-up reports on your patient’s quit journey.

www.QuitWorksRI.org

QuitWorks-RI connects patients to:
- Free telephonic counseling with a certified Tobacco Treatment Specialist (TTS)
- Free Nicotine Replacement Therapy (NRT) as gum, patches, and lozenges (while supplies last)
- Customized quit plans

www.QuitWorksRI.org

HARD, YES. IMPOSSIBLE, NO.
Insured or uninsured, trying to quit or helping a smoker quit, we can help.
Impact of Different Factors on Risk of Premature Death

Source: Schroeder, SA (2007). We Can Do Better- Improving the Health of the American People. NEJM. 357:1221-8
“Public Health and Workplace Safety Act” passed in June 2004. Exemptions: Casinos, Smoking Bars, outdoor spaces such as beaches and parks.

❌ There is no risk-free level of exposure to secondhand smoke exposure. Secondhand Smoke is a US EPA Class A Carcinogen.

❌ Exposure to secondhand smoke leads to stroke, nasal irritation, lung cancer, coronary heart disease and reproductive issues in adults. SHS exposure is now known to increase the risk of strokes in nonsmokers by up to 30%.

❌ Secondhand smoke exposure is higher among people with low incomes. Most exposure to secondhand smoke occurs in homes and workplaces.

❌ Secondhand smoke drifts from unit to unit through air ducts, under doors, holes for piping, electrical outlets, wall and ceiling fixtures, exterior windows, and other pathways.

http://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/general_facts/
Live Smoke Free Program

Live Smoke Free Campaign launch 2011

- Campaign kick off using traditional and social media.
- Live Smoke Free web site with downloadable, property manager & resident toolkits, fact sheet and publications.
- Individual technical assistance for PHAs, boards, resident councils and affordable property management groups.
- No cost quarterly workshops for all property types.
- Scope expanded to include smoke free beaches, parks and tobacco free college campuses.

www.livesmokefree.ri.gov
Rhode Island Smoke Free Public Housing Authorities

As of 5/1/2015 Data Source: Rhode Island Tobacco Control Program

<table>
<thead>
<tr>
<th>Description</th>
<th>PHAs with smoke free policies</th>
<th>All PHAs in state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of PHAs</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Number of Units</td>
<td>9266</td>
<td>9467</td>
</tr>
<tr>
<td>Number of residents</td>
<td>15436</td>
<td>15686</td>
</tr>
</tbody>
</table>
Health Equity Zone (HEZ) Goals

- Defined geographic location; place-based
- Use of local assessments to establish baseline;
- Community assets mapping and community readiness;
- Collective impact framework;
- Sustainability

- HEZ are contiguous geographic areas that have measurable and documented health disparities, poor health outcomes, and identifiable social and environmental conditions to be improved.
  - HEZ must be “small” enough so the plan of action/interventions can have a significant impact on the population (5K minimum)
Health Equity Zone (HEZ) Goals

- Improve health of communities with high rates of illness, injury, chronic disease, or other adverse health outcomes
- Improve birth outcomes
- Reduce health disparities
- Improve the social and environmental conditions of the neighborhood
- Support the development and implementation of policy and environmental change interventions
## Addressing Nutrition

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DAILY</th>
<th>3 MEALS, 2 SNACKS</th>
<th>3 MEALS, NO SNACK</th>
<th>PREPARATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL KCALS</strong></td>
<td>1,500-2,000 kcal (average low-average high)</td>
<td>550 kcal</td>
<td>175 kcal</td>
<td>670 kcal</td>
</tr>
<tr>
<td><strong>SODIUM</strong></td>
<td>≤ 2,000 mg</td>
<td>≤ 550 mg</td>
<td>≤ 175 mg</td>
<td>≤ 660 mg</td>
</tr>
<tr>
<td><strong>CHOLESTEROL</strong></td>
<td>≤ 250 mg</td>
<td>≤ 65 mg</td>
<td>≤ 28 mg</td>
<td>84 mg</td>
</tr>
<tr>
<td><strong>CARBOHYDRATES</strong></td>
<td>55% of daily caloric intake (210-275 g for 1500-2000 kcal diet)</td>
<td>50-80 g (1.5-2 oz)</td>
<td>15-30 g (0.5-1 oz)</td>
<td>100 g (≤ 3.5 oz)</td>
</tr>
<tr>
<td><strong>DIETARY FIBER</strong></td>
<td>&gt; 30 g</td>
<td>&gt; 7 g</td>
<td>&gt; 4.5 g</td>
<td>&gt; 10 g</td>
</tr>
<tr>
<td><strong>TOTAL FAT</strong></td>
<td>30% of daily caloric intake (50-87 g for 1500-2000 kcal diet)</td>
<td>≤ 20 g</td>
<td>≤ 12 g</td>
<td>≤ 28 g</td>
</tr>
<tr>
<td><strong>SATURATED FAT</strong></td>
<td>≤ 10% of daily caloric intake for fat (5-7 g for 1500-2000 kcal diet)</td>
<td>≤ 2 g</td>
<td>≤ 1.2 g</td>
<td>≤ 3 g</td>
</tr>
<tr>
<td><strong>TRANS FAT</strong></td>
<td>0% added trans fats</td>
<td>0% added</td>
<td>0% added</td>
<td>0% added</td>
</tr>
<tr>
<td><strong>LIQUID FATS AND OILS</strong></td>
<td>2-3 tsp (34-45 g)</td>
<td>9-12 g</td>
<td>3.5-4.5 g</td>
<td>12-15 g</td>
</tr>
<tr>
<td><strong>ADDED SUGAR</strong></td>
<td>&lt; 5 Tbsp (75 g) per week</td>
<td>1 Tbsp (15 g) per day</td>
<td>none</td>
<td>1 Tbsp (15 g) per day</td>
</tr>
<tr>
<td><strong>FRUITS &amp; VEGETABLES</strong></td>
<td>12-16 oz (350-454 g) fruit, 20.24 oz (587-680 g) vegetables, variety of colors and types</td>
<td>8-10 oz (227-285 g)</td>
<td>4.5 oz (136-142 g)</td>
<td>11-13 oz (312-360 g)</td>
</tr>
</tbody>
</table>

**Preparation Tips:**
- The daily recommended intake is 3 meals, 2 snacks with calories (kcal) distributed evenly across meals (breakfast, lunch, and dinner). Meal breakdown recommendations are based on a 2,000 kcal diet.
- Avoid processed and preserved foods to limit sodium levels. Utilize spices and fresh herbs as much as possible.
- Replace or eliminate high cholesterol foods in your recipe with lower cholesterol options like egg whites and lean cuts of meat.
- When at all possible, use complex carbohydrates; no fried, high sugar foods.
- Choose ingredients high in fiber whenever possible.
- Using low-fat proteins and finishing with fats that are liquid at room temperature helps to reduce the total fat in a dish.
- Low saturated fat items should be used whenever possible; substitute liquid fats and oils listed below when possible.
- Certain foods naturally contain trans fats; additional trans fats should not be added due to associated increase of LDL cholesterol.
- Use monounsaturated, and polyunsaturated fats like olive, peanut, canola, corn, soybean, safflower, and sesame oils.
- Limit added sugars to any meal. If needed, add sugar to one meal in total menu for day.
- 50% of meal should be a variety of colorful, low starch fruits and/or vegetables. Potatoes, corn, and other starchy vegetables should be counted as carbohydrates.
HEALTHCENTRIC ADVISORS

Brenda Jenkins
QIN-QIOs

• CMS’s QIO Program Approach to Clinical Quality – Triple Aim:

- Better Health
- Better Care
- Lower Cost

• QIN-QIOs are regional, multistate entities providing services to 2 to 6 states for 5 year contracts

• Highly competitive proposal process - only 14 QIN-QIO contracts were awarded
New England QIN-QIO

• Two successful QIOs pool expertise and resources to engage beneficiaries and providers in improving care, improving health and reducing costs across New England

• Identified throughout six-state region as:
New England QIN-QIO

• Led and administered by Healthcentric Advisors
  – Focus areas: MA, ME, RI

• Partner – Qualidigm
  – Focus areas: CT, NH, VT
Cardiac Health

“You’ve got the blood pressure of a teenager – who lives on junk food, TV and the computer.”
Cardiac Health
Task Goals

Improve Cardiac Health implementing Million Hearts® ABCS:

– **A**spirin therapy
– **B**lood pressure control
– **C**holesterol control
– **S**moking cessation

• Reduce Cardiac Healthcare Disparities
Cardiac Health
Task Goals

Increase Electronic Data Reporting

• Physician Offices
  • 8 practices (30 providers)
  • The Physician Quality Reporting System (PQRS)

• Home Health Agencies
  • 14 HHAs
  • HHQI National Cardiovascular Data Registry
Improvement Strategies

• Implement Team Care Model
• Data capture
• Actionable data analysis
• Workflow evaluation and redesign
• PDSAs to mitigate barriers
• Sharing Million Hearts & HHQI tools & resources
• Spreading best practices
Case Study

Internal Medicine practice
• EHR- PQRS reporting on HTN control
• PCMH
• 6 Providers
  – 5 providers scoring well above the state median (65%)
  – 1 provider scoring below state median (60%)
Interventions

• Team engagement
• Education on proper technique
• Correction to documentation
• BP at every visit not just annual exam
• Outreach calls for follow-up visits
• BP Action Plan Information sheets for pts
Case Example
HTN Control

Percentage

<table>
<thead>
<tr>
<th>Date</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/3/2015</td>
<td>60.60%</td>
</tr>
<tr>
<td>3/31/2016</td>
<td>67.20%</td>
</tr>
<tr>
<td>6/30/2016</td>
<td>75.60%</td>
</tr>
</tbody>
</table>
Sustainability

• Continue quarterly data analysis
• Continue BP at every visit
• Increase pt engagement
  – Shared decision making
  – Action plans
• Follow-up visits
• Team Engagement
Q & A
Overview of the American Heart Association and Programs and Resources that align with Million Hearts®
Mission
Building healthier lives, free of cardiovascular diseases and stroke.

Our 2020 Impact Goal
By 2020 to improve the cardiovascular health of all Americans by 20% while reducing deaths from cardiovascular diseases and stroke by 20%.
Building a Culture of Health

A culture in which people live, work, learn, play and pray in environments that support healthy behaviors, timely quality care and overall well-being.
AHA and Million Hearts®
Spotlight on Rhode Island

Advocacy Priorities

• Healthier Food Choices in Public Places
• School Marketing
• Physical Education
• Bikeway Development
• Tobacco Control Funding
• Tobacco 21
AHA and Million Hearts® Spotlight on Rhode Island

Target BP

- Nationwide initiative to help healthcare providers and patients achieve better blood pressure control at the best levels to improve health
- Support physicians and care teams in helping their patients with high blood pressure reach a blood pressure goal of lower than 140/90 mm Hg, based on current AHA guidelines
AHA and Million Hearts®
Spotlight on Rhode Island

Target BP

• Health Impact: Driving toward moving 13.6 million individuals from uncontrolled to controlled blood pressure, through Federally Qualified Health Centers (FQHC) and clinics serving underserved/vulnerable populations and clinics within large healthcare systems.
AHA and Million Hearts®
Spotlight on Rhode Island

Multicultural Health Priorities/Target BP

- Increase # of registered FQHCs and clinics
- Increase # of adult patients reached
AHA and Million Hearts® Spotlight on Rhode Island

Multicultural Health Priorities/Target BP

- Face to Face meeting with clinical lead
- Provide trainings on Target: BP tools and resources
- Equip clinics with consumer education tools
- Consulting services provided
- Clinical lead or team invited and attending workshop/webinar or hospital recognition event
The Guideline Advantage (TGA)

TGA Fact Sheet

- Million Hearts Measures in TGA: High Blood Pressure Control, Tobacco Use Screening, Tobacco Use Cessation Intervention, Ischemic Vascular Disease Use of Aspirin or Other Antithrombotic

- New as of Aug 8, 2016 – physicians at TGA participating practices may now receive Maintenance of Certification Improvement in Medical Practice (Part IV) credit for their engagement
Tools and Resources

• AHA online tools:
  – Heart 360
  – My Life Check®
  – Heart Attack Risk Calculator
• Sodium Leadership Community
• Multi-Cultural/Faith-based Initiatives: EmPowered to Serve
• Get With The Guidelines (TGA) hospital-based quality improvement program
• Communications
• Healthy Workplace Food & Beverage Toolkit
• You’re the Cure – www.yourethecure.org
Discussion

1. Is there a program you were unaware of that you would like to explore further for implementation or application in the state?

2. On which topics would you like additional information?

3. Other questions
Overview of the American Heart Association and Programs and Resources that align with Million Hearts®
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A culture in which people live, work, learn, play and pray in environments that support healthy behaviors, timely quality care and overall well-being.
AHA and Million Hearts® Spotlight on Idaho

Advocacy Priorities

• Health Insurance Coverage - Close the Gap
• Time Sensitive Emergencies - Stroke and STEMI Designations and Registries
• Healthy and Active Programs - Safe Routes to School, P.E.
• Tobacco Free – Smoke Free Air, Tobacco Free Idaho, Tobacco to 21
Advancing Million Hearts®:
AHA and Heart Disease and Stroke Prevention Partners Working Together in Idaho

July 27, 2016

Do you know THE FACTS ABOUT HBP?

HBP EFFECTS NEARLY 80 MILLION AMERICANS
AND IS A LEADING FACTOR FOR HEART DISEASE AND STROKE
AHA | ASA 2020 Goal

AHA 2020 GOAL

Improve the CV health of all Americans by 20% while reducing deaths from CV diseases and stroke by 20%.

2010
Reduce CHD, stroke, and risk by 25%.

2020
Move 13.6 million Americans to control their HBP.
The Urgency Around High Blood Pressure Control

80 million adults have HBP

<table>
<thead>
<tr>
<th>Blood Pressure Category</th>
<th>Systolic (mmHg)</th>
<th>Diastolic (mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal / Ideal</td>
<td>less than 120</td>
<td>and</td>
</tr>
<tr>
<td>Prehypertension</td>
<td>120-139</td>
<td>or</td>
</tr>
<tr>
<td>Hypertension stage 1</td>
<td>140-159</td>
<td>or</td>
</tr>
<tr>
<td>Hypertension stage 2</td>
<td>160 or higher</td>
<td>or</td>
</tr>
<tr>
<td>Hypertensive crisis</td>
<td>higher than 180</td>
<td>or</td>
</tr>
</tbody>
</table>

1 in 3 Americans is living with HBP today

Every 10 Point Drop in systolic BP ≈ 30-50% drop in risk of cardiovascular disease & stroke.

AHA 2015 Statistical Update
The Urgency Around High Blood Pressure Control

HBP IS ONE OF THE MOST EXPENSIVE HEALTH CONDITIONS FOR U.S. EMPLOYERS

ESTIMATED DIRECT & INDIRECT COST OF HBP*

*Includes missed work days, cost of healthcare services and medication expenses.
BIG BET: REDUCE HIGH BLOOD PRESSURE

HEALTHY LIVING STRATEGIES (ESPECIALLY ↓ SODIUM) +

TARGET: BP/ THE GUIDELINE ADVANTAGE

STRATEGIC ALLIANCES (AMGA, AMA, ETC.)

FIELD STAFF & STATE DOH DRIVE ALGORITHM

BIG BETS

HBP TREATMENT ALGORITHM IN CLINICS

BIG BETS

COMMUNITY CONNECTIONS TO CLINICS

EMERGING STRATEGIES

COMPLEMENTARY STRATEGIES

CORE QUALITY MEASURES
COLLABORATIVE DECISION TO INCLUDE DUAL MEASURES FOR BP CONTROL

COMMUNITY CONNECTIONS IN CLOSED SYSTEMS

HEADWINDS

EHR INCENTIVE PROGRAM MEASURES

SPRINT STUDY RESULTS

COMMUNITY PLAN 2.0

RETAIL PHARMACY STRATEGIES

POLICES SUPPORTING SMBP

FEDERAL REGULATIONS INCENTIVIZING HCP’S TO BETTER PERFORMANCE

American Heart Association
American Stroke Association
life is why
Check. Change. Control.™
Building a Sustainable HBP Program

Clinical Pharmacists 2008 – 2010
- Remote Monitoring Study via Kaiser Clinical Pharmacists
- Six month SBP control significantly higher than control group. Suggests healthcare cost saving

Community Settings 2010 - 2011
- Check It. Change It. Community-based intervention in Durham County
- In patients that began the study with a BP of > 150/90, systolic BP decreased by 24.2 mmHg and diastolic BP decreased by 10 mmHg.

Enlisting Partners 2012 - Present
- AHA joined with Million Hearts to host a forum that included partners across industries positioned to impact the issue of HBP
- Initial meeting was the impetus for the launch of AHA’s HBP Leadership Community based on attendees’ desire to continue the innovation, sharing and exchange of solutions

Innovation in the Field 2012 - 2013
- Check It. Change It. set the stage for larger, community-based model run by the AHA focused on high-risk pop.
- Grants to local market staff designated for rapid development, execution and testing of programs using partners and volunteers.
- Similar results to Check It. Change It. Lowering BP by 5 mmHG, with more significant drops between 11mmHg and 26 mHG in high risk groups
Why it Works: Key Evidence-Based Scientific Principles

Self Monitoring Makes a Difference
Proven track record for taking blood pressure readings at home or outside of the healthcare provider office setting.
- Use of digital self-monitoring and communication tool
- Charting & tracking improves self-management skills related to blood pressure management

Personal Interaction Makes a Difference
Health mentors can motivate and encourage participants.

Multicultural Program Investments Make a Difference
Hypertension creates a health disparity for African-Americans.
Program Components

Community Partners with Shared Goals to Drive BP Control

Since August, 2012 over 46,000 participants have enrolled in Heart360

**Campaign Results***:
Average drop in Systolic BP: 11.02 mm Hg
Average drop in Diastolic BP: 7.68 mm Hg

Innovative Implementation Across Markets

Health Mentors Encourage Participants to Track Weekly Readings for 4 Months

Central BP Tracking Tool for Participant Engagement and Data Collection
Benefits extend even with partial engagement:

Even those participants who did not meet the full retention criteria saw declines in BP numbers.

WHAT DO THESE RESULTS MEAN?

Also, a 5mmHg reduction in systolic blood pressure would increase the prevalence of ideal blood pressure from 44.26% to 65.31%
Target: BP is a national movement aimed at improving blood pressure control, to reduce the number of Americans who have heart attacks and strokes. Target: BP provides physician practices and health systems resources and support to achieve a 70% blood pressure control rate with a target of achieving 80% or higher.
Why launch Target: BP now?

- **SPrINT study results**
- **Increased access to care**
- **Policies incentivize HCP’s to better control**
- **AHA 2020 goals are imminent**
- **Synergizing with Million Hearts program**
What is Target: BP?

A call to action motivating hospitals, medical practices, practitioners and health services organizations to prioritize blood pressure control

Recognition for healthcare providers who attain high levels of blood pressure control in their patient populations, particularly those who achieve 70 or 80 percent control

A source for tools and assets for healthcare providers to use in practice, including the AHA/ACC/CDC Hypertension Treatment Algorithm and the AMA’s M.A.P. Checklist
The 2015 M.A.
Measure accurate BP

Protocols to guide evidence-based prescribing

**FAST FACTS**

**IHO: BP – Measure accurate BP**

**IHO**

Did you know?

National experts recommend that clinical teams use hypertension treatment protocols to manage patients with hypertension. Just as a football team playbook describes what players should do during a play, a treatment protocol clearly spells out what a care team should do.

**Why are protocols important?**

Studies show that getting blood pressure under control quickly reduces the risk for heart attack, strokes and even death. Treatment protocols help clinicians and staff work together as a team to identify which patients to treat, when to treat them, what medications to use, what the target blood pressure should be and how often follow-up should occur. However, it is important to note that clinicians should not use a protocol to replace sound medical decision making for a given patient’s unique situation.

**Where can you find examples of evidence-based treatment protocols to use?**

If your organization has not already developed an evidence-based treatment protocol, the Million Hearts® Initiative has a web page containing several examples of evidence-based treatment protocols for improving blood pressure control located at [https://mhhn.figueroaCHASE.com/Protocols](https://mhhn.figueroaCHASE.com/Protocols). These evidence-based treatment protocols help the clinical team address:

- When patients should receive treatment
  - Establish minimum initiation cut points—in the case of the Million Hearts® Inactive protocol for controlling hypertension in adults, the treatment initiation cut off is at a 150 mm/Hg systolic
d  - Blood pressure (to less than 150 mm),
- Blood pressure is recommended for most patients
  - Evidence-based therapies change—such as losing weight, using the dietary approaches to stop hypertension (DASH) eating plan or engaging in regular aerobic exercise—can reduce a patient’s systolic blood pressure by 5 to 15 mm Hg.
  - Four medication classes are recommended for most patients: thiazide diuretics, calcium channel blockers, and either an ACE inhibitor or ARB, but not both.
  - Single-pill combination therapy is recommended for patients with high blood pressure, especially those with a baseline pressure of 160/105 mm Hg or higher.
  - More patients up to 90 percent of those on the ALL HAT trial should be able to achieve blood pressure control by using one of these medications.
- How a practice or health center should follow up after treatment begins
  - Early and frequent follow-up (every 1 to 4 weeks) is recommended so that patients can be advised to adjust their routine treatment until their blood pressure is controlled.
  - Keep in mind that follow-up does not always have to mean a visit with a primary care provider. Many practices or health centers have built successful follow-up programs around self-measured blood pressure monitoring or drop-in blood pressure check with medical assistants or RNs.

| Life is why |
| American Heart Association | American Stroke Association |
Elements Associated with Effective Adoption of Protocols

Practice Team-Base Care

- Make hypertension control a priority.
- Fully use the expertise and scope of practice of every member of the health care team.
- Include the patient and family as key members of the team.
- Learn about community resources and recommend them to patients.
- Conduct pre-visit planning to make the most of the care encounter.
- Look for opportunities to check in with patients between visits and adjust medication dose as needed.
Tools and Resources

Online Tools
• Heart 360
• My Life Check
• Heart Attack Risk Calculator
• High Blood Pressure Risk Calculator
• AHA’s Smoking Cessation Tools and Resources
• AHA Healthy Workplace Food and Beverage Toolkit July 2016

Resources
• EmPowered to Serve
• Get With The Guidelines
• Check.Change.Control
Discussion

1. Is there a program you were unaware of that you would like to explore further for implementation or application in the state?

2. On which topics would you like additional information?

3. Other questions
LUNCH BREAK
Partners, Programs and Persons That Align
Ways to Work Together
and
Next Interactions
How did this meeting benefit you and your organization?

Do you have suggestions on improving the overall format for this meeting?
Thank you for your participation!
Control Is Their Goal: Million Hearts Recognizes the 2015 Hypertension Control Champions

18 Champions are being recognized for achieving high rates of blood pressure control for their patients.

Press Release
For immediate Release: Thursday, May 5, 2016
Contact: Media Relations
(404) 639-3286

The 2015 Hypertension Control Champions used evidence-based strategies and patient engagement to help their patients achieve blood pressure control rates at or above the Million Hearts target of 70 percent. The 18 Champions, ranging from small practices to large health care systems throughout the U.S., provide care to nearly 1.5 million adults.

“Clinicians are our first line of defense against the hundreds of thousands of deaths caused by high blood pressure each year,” said CDC Director Tom Frieden, M.D., M.P.H. “We applaud the 2015 Champions and hope other health care teams learn from these successes and save even more lives.”

Nearly 1 in 3 American adults has high blood pressure, a leading cause of heart disease and stroke. Nearly half of adults with high blood pressure do not have their condition under control. Even more alarming, millions of Americans have high blood pressure that is undiagnosed or untreated. High blood pressure may also contribute to the development of dementia. The U.S. Department of Health and Human Services launched the Million Hearts national initiative, with public and private partners, in 2011.

The 2015 Million Hearts Hypertension Control Champions are:

- AHRC Health Care Inc. (dba Access Community Health Center); New York City
- Albany Area Primary Health Care Inc.; Albany, Georgia
- Altru Health System; Grand Forks, North Dakota
- Atrius Health; Newton, Massachusetts
- Baltimore Medical System at Middlesex; Baltimore
- Hamakua Kohala Health; Honokaa, Hawaii
- International Community Health Services; Seattle
- Jason Infeld, M.D., FACC, Stern Cardiovascular Foundation; Germantown, Tennessee
- Kaiser Permanente Georgia and The Southeast Permanente Medical Group; Atlanta
- Kelsey-Seybold Clinic; Pearland, Texas
- Mercy Clinic East Communities; St. Louis, Missouri
- OHSU Family Medicine at Richmond; Portland
- Petaluma Health Center; Petaluma, California
- Reliant Medical Group; Worcester, Massachusetts
- Thundermist Health Center; Woonsocket, Rhode Island
- Unity Family Medicine at St. Bernard’s; Rochester, New York
- WESTMED Medical Group; Purchase
- Zufall Health Center; Dover, New Jersey
Saving lives through better blood pressure control has been a longstanding CDC priority. By recognizing the Champions’ performance and sharing their lessons learned, CDC aims to help other health care professionals achieve the same success in communities nationwide.

“We are excited to host this Challenge and showcase successful strategies used by our 2015 Champions to keep blood pressure under control, prevent heart attacks and strokes, and save lives,” said Janet Wright, M.D., a board-certified cardiologist and executive director of Million Hearts.

“Health care teams can follow our Champions’ lead to take steps to identify patients in their practice who are at risk for or who have high blood pressure and connect them to the care they need.”

To be eligible, entrants shared verifiable high blood pressure control data and highlighted successful strategies and best practices adopted by the practice or system, such as the use of health information technology and team-based care. All Champions achieved control rates of 70 percent or greater for their adult patients by using a variety of approaches, including:

- Making high blood pressure control a priority
- Using evidence-based treatment guidelines and protocols
- Using health care teams to increase the frequency of contact with patients
- Implementing consistent, strategic use of electronic health records that include clinical decision support tools, patient reminders, and registry functionality
- Staying engaged with patients by offering free blood pressure checks and implementing the use of a patient navigator or care coordinator

Million Hearts is a national initiative to prevent 1 million heart attacks and strokes in five years. CDC co-leads Million Hearts with the Centers for Medicare & Medicaid Services. For more information about the initiative and to access resources, visit http://millionhearts.hhs.gov.
Online Tools

- **Heart360** ([www.heart360.org](http://www.heart360.org)) – Heart360® is an easy-to-use tool which helps you understand and track the factors that affect your heart health - including blood pressure, physical activity, cholesterol, glucose, weight, and medications.

  Get a full heart health assessment with this tool based on many years of research.

  Enter your latest blood pressure reading to learn your risk of having a heart attack, a stroke, and developing heart failure and kidney disease. You'll also learn how a few lifestyle changes can lower your blood pressure and your health risks. You can print your risk report to review and discuss with your healthcare professional.

- **AHA’s Smoking Cessation Tools and Resources**
  [http://www.heart.org/HEARTORG/GettingHealthy/QuitSmoking/Quit-Smoking_UCM_001085_SubHomePage.jsp](http://www.heart.org/HEARTORG/GettingHealthy/QuitSmoking/Quit-Smoking_UCM_001085_SubHomePage.jsp)

- **AHA Healthy Workplace Food and Beverage Toolkit July 2016**
  [http://www.heart.org/HEARTORG/GettingHealthy/WorkplaceWellness/WorkplaceWellnessResources/Healthy-Workplace-Food-and-Beverage-Toolkit-Resources_UCM_465206_Article.jsp](http://www.heart.org/HEARTORG/GettingHealthy/WorkplaceWellness/WorkplaceWellnessResources/Healthy-Workplace-Food-and-Beverage-Toolkit-Resources_UCM_465206_Article.jsp)
Resources

  The AHA supports coverage of preventive benefits in private and public health insurance plans. The AHA will encourage states to cover CVD-related U.S. Preventive Services Task Force A and B benefits under Medicaid without cost sharing and achieve the 1% federal payment increase.

- **EmPowered to Serve** ([http://www.empoweredtoserve.org/index.php/about/about-the-movement/](http://www.empoweredtoserve.org/index.php/about/about-the-movement/))
  A multicultural initiative that works to influence faith-based as well as urban housing channels to build strategic alliances that support a “culture of health” through healthy living, enhancing the chain of survival, and improving the environment.

- **Check. Change. Control. (CCC)** ([http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/HighBloodPressure-ToolsResources/Check-Change-Control-Blood-Pressure-Program_UCM_449318_Article.jsp#.V5Jo6vIUX4h](http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/HighBloodPressure-ToolsResources/Check-Change-Control-Blood-Pressure-Program_UCM_449318_Article.jsp#.V5Jo6vIUX4h))
  This program empowers multicultural audiences to manage their blood pressure through a combination of resources and utilizes Heart360, a powerful online tool to help track health factors including blood pressure.

- **High Blood Pressure Algorithm** ([http://www.heart.org/HEARTORG/Affiliate/UCM_481444/High-Blood-Pressure-Algorithm-Resource-Page_UCM_481444_SubHomePage.jsp](http://www.heart.org/HEARTORG/Affiliate/UCM_481444/High-Blood-Pressure-Algorithm-Resource-Page_UCM_481444_SubHomePage.jsp))
  Developed in partnership with the Centers for Disease Control and American College of Cardiology, and is a critical tool focused on 8 principles for an effective, systemic and team-based formula for the healthcare setting.
Resources for Clinicians:

- **Hypertension Control: Change Package for Clinicians**
  A quality improvement change package with a listing of process improvements that ambulatory clinical settings can implement as they seek optimal hypertension control.

- **Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians**
  A guide to facilitate the implementation of self-measured blood pressure monitoring (SMBP) plus clinical support in preparing care teams to support SMBP, selecting and incorporating clinical support systems, empowering patients, and encouraging health insurance coverage for SMBP plus additional clinical support.

- **Evidence-Based Hypertension Treatment Protocols**
  A webpage with a hypertension treatment protocol template and featured evidence-based protocols to help clinicians improve blood pressure control by clarifying titration intervals, revealing new treatment options and expanding the types of staff that can assist in a timely follow-up with patients.

- **Tobacco Cessation Protocol**
  A webpage with a tobacco cessation protocol template and featured evidence-based protocols to help clinicians identify patients who use tobacco and systematically deliver appropriate cessation services.

- **Undiagnosed Hypertension**
  A webpage that describes the phenomena of patients with uncontrolled hypertension being seen by clinicians, but remaining undiagnosed; resources, references and case studies are provided to help clinicians find their undiagnosed hypertensive patients.
  - **Hypertension Prevalence Estimator**
    [https://nccd.cdc.gov/MillionHearts/Estimator/](https://nccd.cdc.gov/MillionHearts/Estimator/)
    An interactive tool health systems and practices can use to start or build on their existing hypertension management quality improvement process by comparing the expected hypertension prevalence generated from the tool with their calculated prevalence.

- **Million Hearts® Clinical Quality Measures (CQM)**
  [http://millionhearts.hhs.gov/data-reports/cqm.html](http://millionhearts.hhs.gov/data-reports/cqm.html)
  A webpage that displays national clinical quality measures and targets focused on the Million Hearts® ABCS (Aspirin when appropriate, Blood pressure control, Cholesterol management, and Smoking cessation).
Clinically-focused Programs:

- Million Hearts® Hypertension Control Challenge
  http://millionhearts.hhs.gov/partners-progress/champions/index.html

- Million Hearts® Cardiovascular Disease Risk Reduction Model
  https://innovation.cms.gov/initiatives/Million-Hearts-CVDRRM/

- EvidenceNOW: Advancing Heart Health in Primary Care
  http://www.ahrq.gov/professionals/systems/primary-care/evidencenow.html

Public Health Resources and Programs:

- Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners

- CDC State Heart Disease and Stroke Prevention Programs
  http://www.cdc.gov/dhdsp/programs/index.htm

Tools for Patients:

- Heart Age Predictor
  http://www.cdc.gov/vitalsigns/cardiovasculardisease/heartage.html

- Blood Pressure Wallet Card

- Healthy Eating & Lifestyle Resource Center
  http://recipes.millionhearts.hhs.gov/

- Smoke Free (SF)
  http://smokefree.gov/

- Million Hearts® Videos: Personal Stories
  http://millionhearts.hhs.gov/news-media/media/videos.html#ps

Community Engagement:

- Cardiovascular Health: Action Steps for Employers

- Healthy is Strong
  http://millionhearts.hhs.gov/learn-prevent/healthy-is-strong.html

- 100 Congregations for Million Hearts®
  http://millionhearts.hhs.gov/partners-progress/partners/100-congregations.html

Supportive Campaigns:

- Mind Your Risks
  https://mindyourrisks.nih.gov/index.html

- Tips from Former Smokers
  http://www.cdc.gov/tobacco/campaign/tips/index.html
Goal: Identify hypertension and other Million Hearts® related efforts in the state of Idaho

Overview of Task

- Please use the template on the second page to capture information you would like to share on your organization’s hypertension and other Million Hearts related efforts in Idaho. You can also note initiatives and other ideas you have heard throughout the day of areas you would like to partner on or seek resources.

- You will be asked to share this information during the facilitated group discussion. This document will be collected to provide a summary to the group.

- The facilitator will be listening for this information throughout the day’s presentations and will be capturing it on flip charts under three strategies: Undiagnosed Hypertension, Uncontrolled Hypertension, and Team Based Care. We will also have a flip chart for additional strategies.

- The point of this exercise to hear from you on your programs and interests and better understand what is happening in Idaho around hypertension. It is not meant to create additional work, but rather explore ways to partner or to form alliances but to help each other do our work better and to create synergies around the state.

- Once we hear from all partners, we will have an opportunity to note where we can collaborate with others to help scale and spread the work.

- Finally, we will have a discussion about the key areas noted as partnership opportunities and discuss additional resources and partners necessary to support this work.

- Facilitated Group Discussion Itinerary
  
  1:20pm Attendees complete ideas on the template.

  1:30pm Prioritization exercise/stretch break
  Attendees place circle stickers on areas/projects where their organization can see alignment and may want to partner. (Add name/organization on stickers.)

  1:45pm Discuss group priorities and how partners can align. This information is captured on a fourth flip chart (Coordination and Collaboration) identifying for each selected priority - what, who, and by when
Identifying Hypertension Efforts in Idaho

Partner/Organization Name ____________________________________________

Individual Name ____________________________________________________

Role within your organization __________________________________________

Region (if applicable) ________________________________________________

In the boxes below, please include the following:

1) Activities under each of the categories that you are currently working (focus on main priorities)
2) An area you may like to collaborate on moving forward
3) Resources/tools you have available for others

If you are not working on one of these areas, please feel free to leave it blank. If you have another main priority, feel free to use the space at the end.

**Strategy: Identify Undiagnosed Hypertension**

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**Strategy: Team Based Care**

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**Strategy: Address Uncontrolled Hypertension**

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**Other Strategies:**

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