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

September 25, 2019
Meeting Summary

Lod Cook Alumni Center
Louisiana State University
Baton Rouge, Louisiana
## Table of Contents

### Contents

Meeting Summary................................................................................................................................................................... 3  
What excites you about your work in heart disease and stroke prevention? ................................................................. 4  
Agenda .................................................................................................................................................................................... 5  
Presentations: ......................................................................................................................................................................... 7  
  - Million Hearts® 2022 Update .............................................................................................................................................. 7  
  - Louisiana Department of Health Hypertension Initiatives ........................................................................................................ 8  
  - QIO Hypertension Initiatives .............................................................................................................................................. 9  
  - American Heart Association Hypertension Initiatives ........................................................................................................... 9  
  - Louisiana Partner Hypertension Initiatives .......................................................................................................................... 10  
  - Bogalusa Heart Study and Hypertension ............................................................................................................................. 11  
  - Addressing Maternal Mortality in Louisiana ......................................................................................................................... 11  
  - Sankofa Community Development Corporation .................................................................................................................... 12  
Breakout Group Discussions: ................................................................................................................................................ 14  
  - Group 1: Provider Engagement in Hypertension Management Efforts .................................................................................. 15  
  - Group 2: Self Measured Blood Pressure Monitoring Programs and Clinical Supports ............................................................. 17  
  - Group 3: Clinical-Community Partnerships for Hypertension Management ............................................................................. 21  
Attendee List ......................................................................................................................................................................... 23  
Event Presentation Slides ..................................................................................................................................................... 24  
Partner Profile Summary ....................................................................................................................................................... 43
Meeting Summary

Purpose: To develop a coordinated strategy for addressing hypertension in Louisiana.

Objectives:
1. Increase understanding of the existing hypertension initiatives implemented through various organizations.
2. Identify opportunities for alignment of existing efforts.
   - Increase healthcare provider engagement in hypertension management initiatives
   - Implement self-measured blood pressure monitoring with clinical support
   - Increase community-clinical partnerships for hypertension management
3. Identify gaps in services (populations, geographic regions, etc.)
4. Develop plans for maximizing existing efforts and addressing unmet needs.

Overview
On September 25, 2018, 55 representatives from 22 health organizations devoted to reducing the prevalence of heart disease met in Baton Rouge to advance the mission of the Million Hearts® initiative.

The partner organizations collaborated on ways to align their individual efforts to better meet the Million Hearts® goal of preventing a million heart attacks and strokes over the next five years. Representatives shared information about their organizations’ hypertension management programs and resources to identify alignments, assess opportunities to expand efforts and to fill gaps in services.

Participants then separated into breakout groups to discuss and establish action plans around three priority areas:
   - Identify opportunities to increase healthcare provider engagement in hypertension management initiatives.
   - Identify opportunities to implement self-measured blood pressure monitoring with clinical support.
   - Identify opportunities to increase community-clinical partnerships for hypertension management.

The day’s discussions helped participants expand their knowledge of existing efforts and initiatives addressing hypertension, initiate opportunities for collaboration and share success and lessons learned with peers.

Approximately 20 of the 51 participants responded to the post meeting evaluation survey. Of those who responded, 44% participated in the discussion about increasing healthcare provider engagement in hypertension management initiatives; and 28% participated in each of the remaining two groups. Feedback reflected the depth and value of information yielded from discussions. Participants appreciated the opportunity to identify new partners, learn about existing efforts, obtain new tools and resources as well as network with colleagues.

Suggestions for next steps include developing a plan for maintaining momentum and continuing regular communication, establishing a regular meeting schedule every 4-6 months and increasing organizational representation on the group.
What excites you about your work in heart disease and stroke prevention?

The follow responses were shared by meeting participants:

- Ways to make Louisiana healthier.
- More information on hypertension that I can bring back to my community.
- Improving the health of Louisiana.
- Identifying opportunities to help us all support heart disease prevention efforts.
- Aligning all our teams together.
- Learning from the partners that we already have to make sure that we collaborate and do more work here.
- Shaping the work that I do each and every day.
- Hearing from all of you and hearing what’s working, what isn’t working, and figuring out how to pull together.
- Stronger partnerships after today.
- Learning how we can connect the people in the capital area to let them know the resources that are available to them.
- Increase engagement with providers through our provider engagement network.
- Learn how we can collaborate on a few of our relationships.
- Build a bidirectional referral process between our clinic and the physicians’ office.
- Build partnerships and to see what other agencies are doing when it comes to managing hypertension.
- Expand our community outreach to prevent heart disease and stroke and better understand the needs of our community.
- Hearing what programs are available for partnering so that we can make an impact in our communities.
- Learning about fun and innovative ways to be able to engage our community and be aware of the hypertension issues that we do have.
- Bring education to our rural community and the capital area.
- Transforming the health care system.
- Take the lessons learned from this process and help other states as well.
- Connect with other groups who can help us and produce health outcomes.
- Looking at the social determinants of health.
- Developing strategic partnerships in Louisiana and to be able to translate this beyond these four walls.
- Take back ideas on how to operationalize blood pressure control.
- Take back information to our providers and then therefore to our patients to help them live a better, healthier life.
## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item/Topic</th>
<th>Speaker/Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:00 am</td>
<td>Partner Networking</td>
<td></td>
</tr>
</tbody>
</table>
| 9:00 – 9:15 am  | Welcome                                                                          | **John Clymer** Executive Director, National Forum for Heart Disease and Stroke Prevention  
|                 | Overview of the Day                                                              | **Julie Harvill** Operations Manager, Million Hearts Collaboration, American Heart Association |
| 9:10-9:30       | Introductions In one sentence, what excites you about your role in heart disease and stroke prevention? | **John Bartkus**, PMP, CPF Principal Program Manager, Pensivia                          |
| 9:30 – 9:45 am  | Million Hearts® 2022 Q and A - Group Interaction                                  | **Tiffany Fell** Deputy to Associate Director  
|                 |                                                                                 | Policy, External Relations, and Communications Office  
|                 |                                                                                 | Division for Heart Disease and Stroke Prevention  
|                 |                                                                                 | National Center for Chronic Disease Prevention and Health Promotion, CDC               |
| 9:45 – 10:00 am | Louisiana Department of Health Hypertension Initiatives                         | **Melissa R. Martin**, RDN, LDN Well-Ahead Louisiana Director                           |
| 10:00 – 10:15 am| Quality Insights, Quality Innovation Network                                     | **Debra Rushing** Cardiac, Louisiana State Lead                                        |
| 10:15-10:30 am | American Heart Association Hypertension Initiatives                            | **Ashley Hebert**, MPA Government Relations Director, Louisiana  
|                 |                                                                                 | **Coretta LaGarde** VP, Health Strategies, Louisiana                                   |
| 10:30 – 10:45 am| Break                                                                            |                                                                                      |
| 10:45-12:00 pm | Louisiana Partner Hypertension Initiatives Partnering with providers to implement sustainable systems changes | **Kenny J. Cole**, MD, MHCDS System VP, Clinical Improvement Ochsner Health System  
|                 | Bogalusa Heart Study and Hypertension                                            | **Camilo Fernandez**, MD, MSc, MBA Senior Research Scientist Center for Lifespan Epidemiology Research Department of Epidemiology, Tulane University School of Public Health and Tropical Medicine  
|                 |                                                                                 | **Veronica Gillispie-Bell**, MD, FACOG Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review  
|                 | Louisina Perinatal Quality Collaborative                                          | **Danelle Guillory**, MD, PhD Healthy HeartBeats Program  
|                 |                                                                                 | **Colleen Arceneaux**, MPH Population Health Manager, Well-Ahead Louisiana, Louisiana Department of Health / Office of Public Health |
| 11:25 – 11:45 am| Finding Connections and Alignments                                               | **John Bartkus**                                                                        |
| 12:00 pm        | Lunch                                                                            |                                                                                      |
### Afternoon Breakouts/Facilitated Discussions

- Provider engagement in hypertension management efforts
- Self-measured blood pressure monitoring with clinical support
- Clinical-community partnerships for hypertension management

**Moderator:** John Bartkus

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:45 – 2:20 pm</td>
<td>Afternoon Breakouts/Facilitated Discussions</td>
<td>John Bartkus</td>
</tr>
<tr>
<td>2:20 – 2:50 pm</td>
<td>Group Report Outs and Next Steps</td>
<td>John Bartkus</td>
</tr>
<tr>
<td>2:50 – 3:00 pm</td>
<td>Evaluation and Feedback Process</td>
<td>Sharon Nelson, MPH</td>
</tr>
<tr>
<td>3:00 pm</td>
<td>Wrap Up/ Adjourn</td>
<td></td>
</tr>
</tbody>
</table>
Presentations:
The following are highlights of presentations shared by meeting participants. The full presentations can be found at the end of the report.

**Million Hearts® 2022 Update**
*Tiffany Fell, Deputy Associate Director, PERC*
*Division for Heart Disease and Stroke Prevention, CDC*

![Million Hearts® 2022 Priorities Diagram]

We project 279,300 “Million Hearts preventable events” that will occur in LA if we do nothing

- 6% reduction of those events = 16,800 events we hope LA will prevent

**Resources:**
- **Action Guides**—Hypertension control; Self-measured blood pressure monitoring (SMBP); newly released Tobacco cessation; Medication adherence
- **Protocols**—Hypertension treatment; Tobacco cessation; Cholesterol management
- **Tools**—Hypertension prevalence estimator; ASCVD risk estimator
  - **Messages and Resources**—Undiagnosed Hypertension, Medication Adherence, Health IT, SMBP, Particle Pollution, Physical Activity, Tobacco Use
- **Clinical Quality Measures**
- **Consumer Resources and Tools**

**SMBP Forum**
- Access materials via the SMBP Healthcare Community
  Go to [www.healthcarecommunities.org](http://www.healthcarecommunities.org) and log in to your account (free to register)
  Search for ‘SMBP’ under the ‘Available Communities’ tab
  Click “Join Community”
- Questions: MillionHeartsSMBP@nachc.org

- NACCHO Toolkit
Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners  
Working Together in Louisiana – September 25, 2019

- Revised Hypertension Control Change Package- revised version coming in 2019!
- Hospital/Health System Recognition Program- in close collaboration with NACDD, announcement coming in October 2019!
- Million Hearts for Clinicians Microsite- Features Million Hearts® protocols, action guides, and other QI tools; Syndicates LIVE Million Hearts® on your website for your clinical audience.

**Louisiana Department of Health Hypertension Initiatives**

*Melissa Martin*

*Well-Ahead Louisiana Director*

 ![Image](image.png)

See video!

**11 different programs that touch heart disease and prevention efforts**

- Community resource development and Healthy Community Coaching- includes community-clinical partnerships to increase access to programs for their patients. For ex- SMBP programs in the community. Maintains a resource guide found on their website to support individuals and providers (ask Melissa for link?). Additional efforts to enhance infrastructure for CHWs.
- Wellspot Designation [http://wellaheadla.com/WellSpots/Find-WellSpots](http://wellaheadla.com/WellSpots/Find-WellSpots) - over 16 chronic disease programs such as self-assessments for health.
- SMBP Programs and Clinical Support
- Barbershop projects- Cutting the Pressure and other pilot projects. 3 barbers have been trained to do SMBP programming. Based on the outcomes, they will share lessons learned.
- Quit with US. LA- shared partner brand for the 1800 Quit Now quitline offering NRT and cessation counseling via phone, web, and soon text.
- WISEWOMAN
- WELL AHEAD [http://wellaheadla.com](http://wellaheadla.com)
- Practice Coaches- working in clinical setting working with providers who are interested in these initiatives
- Population Health Cohort- focused on quality initiatives.
- Medication Adherence and Therapy Management- working with clinical pharmacy in several interventions.
- Stay connected at [www.walpen.org](http://www.walpen.org)
QIO Hypertension Initiatives
Debra Rushing
Cardiac, Louisiana State Lead

The QIN-QIO Program’s Approach to Clinical Quality

Cardiovascular Health

- Directives - Stroke prevention, HTN and smoking cessation
- Promoted Million Hearts website, best practices, resources
- Encouraged/increased use of BP protocols in practices and HHAs
- Promoted use of HHQI’s cardiovascular data registry in home health setting
- Developed/promoted Quality Insights resources specific to stroke & BP
- Innovative resource distribution to beneficiaries through food commodity boxes in rural areas, Meals on Wheels
  - Work with clinician practices on whether they have a protocol in place and they help them get one in place.
  - Work with data registry.
  - All the QIO work is free and you can get CEU’s by being trained through various resources.

American Heart Association Hypertension Initiatives
Ashley Hebert, Government Relations Director, Louisiana
Coretta LaGarde, VP, Health Strategies, Louisiana

- Check.Change.Control
- TargetBP
- Get With the Guidelines
- HeartCheck products in grocery stores- working with New Orleans and Baton Rouge grocery stores
- A newer initiative- Know Diabetes By Heart- combat diabetes across Louisiana
- Spotlight on Louisiana- listing hospitals involved in Stroke care
- AHA Advocacy- Healthy Eating/Active Living and Tobacco Free
Online Tools
- AHA Louisiana Facebook Page
- Sign up for You’re the Cure; http://www.yourethecure.org
- My Life Check
- Heart Attack Risk Calculator
- AHA’s Smoking Cessation Tools and Resources
- AHA’s Workplace Health Solutions

Resources
- EmPowered to Serve
- Get With The Guidelines; www.heart.org/quality
- Target: BP

Know Diabetes By Heart

**Louisiana Partner Hypertension Initiatives**

*Kenny Cole, Systems VP*

*Clinical Improvement, Ochsner Medical Center*

**Measure Up Pressure Down AMGA program**

Evidence Based Program-
- Includes key steps in measurement, goals, ancillary testing, life style modifications, and patient engagement strategies
- Flows pathway for medication prescription and follow up visits based on how far BP is out of control
- Identifies additional tests for treatment resistant hypertension
- Lists drug names, dosages, and notes by mediation category for both mono therapy and combination therapy
Bogalusa Heart Study and Hypertension
Camilo Fernandez Alonso
Department of Epidemiology, Center for Cardiovascular Health
Tulane University School of Public Health and Tropical Medicine
New Orleans, Louisiana

- One of the longest on-going studies of a biracial, semi-rural community in the Southern US. Our focus is on understanding the impact of cardiovascular and metabolic changes on health throughout the lifespan.
- 170+ studies/sub-studies have been conducted over the years, which include special studies on socioeconomic evaluations, blood pressure studies, a lipids study, genetic/epi-genetic studies, exercise, heart murmur studies, newborn cohort, diabetes, pathology, and CV imaging
- More than 1,000 publications, five textbooks and numerous monographs have been produced describing observations on more than 12,000 children and adults in Bogalusa, Louisiana.

Addressing Maternal Mortality in Louisiana
Veronica Gillispie-Bell
Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review Obstetrics & Gynecology
What is the LaPQC?

- Formed in 2016, became an Initiative of Louisiana Commission on Perinatal Care and the Prevention of Infant Mortality in 2018.
- A network of perinatal care providers, public health professionals and patient and community advocates who work to advance equity and improve outcomes for women, families, and newborns in Louisiana
- Required for Level 3 and Level 4 Hospitals
- 37 of 52 birthing facilities are participating

Sankofa Community Development Corporation
Danelle Guillory, Healthy Heartbeats Program

Program Overview
Our programs shape health, influence systematic change and address the social determinants of health that trigger and sustain inequalities

Program Goals
To create a local environment that promotes positive health outcomes & long-term community well-being
To promote personal wellness in alignment with healthy families as the cornerstone of a thriving, cohesive community, for cohesive communities
To build healthier communities for present and future generations
Peer leadership by Community Health Ambassadors (CHA)
- CHAs trained as peer educators and provide ongoing guidance and advisement on program growth and development
- Hypertension and nutrition education using the American Heart Association EmPOWERED to Serve curriculum
- Self-monitoring blood pressure and health measurements
- Access to fresh produce
- Health care provider treatment

Healthy HeartBeats Program Highlights
(August 2017 to July 2018)

- 1,322 participants at six sites completed the Healthy HeartBeats (HHB) program with an average attendance of 75%.
- Average SBP fell from 139/81 to 126/78 (*p < 0.01)
- 95.8% (1,230 out of 1,299 respondents) said they “agreed” or “strongly agreed” that they had increased their physical activity after the program.
- 95.1% (1,165 out of 1,226 respondents) said they “agreed” or “strongly agreed” that they had changed their diet to be more healthy, including avoiding sodium, saturated fat, and sugar and eating more fruits and vegetables after the program.
- 47.9% (67 out of 119 participants) improved knowledge of one or more nutrition topics.
Breakout Group Discussions:
Meeting participants selected one of the following discussion sessions in which to participate.

<table>
<thead>
<tr>
<th>Group</th>
<th>Topic</th>
<th>Co-Facilitators</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physician Engagement in Hypertension Management Efforts</td>
<td>Chelsea Moreau, Latraiel Courtney</td>
<td>Melissa Martin, Julie Harvill, John Clymer</td>
</tr>
<tr>
<td>2</td>
<td>Self-measured Blood Pressure Monitoring</td>
<td>Coretta LaGarde, Danielle Guillory</td>
<td>Katelyn King, Kelly Flaherty, Sharon Nelson</td>
</tr>
<tr>
<td>3</td>
<td>Clinical Referral to Community-based Hypertension Management Programs</td>
<td>Colleen Arceneaux, Brian Burton</td>
<td>Ashley Hebert, Erin Leonard, Julia Schneider</td>
</tr>
</tbody>
</table>

The following notes were taken during each discussion.
# Group 1: Provider Engagement in Hypertension Management Efforts

## ACTIVITIES / RESOURCES
*What is each organization doing? What’s working? What isn’t? What resources can be shared?*

<table>
<thead>
<tr>
<th>Describe Strategies/Approach employed to Increase Provider Engagement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Team-based care</td>
</tr>
<tr>
<td>• Collaborative Practice Agreements with Pharmacists</td>
</tr>
<tr>
<td>• Clinical Decision Support Systems</td>
</tr>
<tr>
<td>• Get with the Guidelines AHA, recognition</td>
</tr>
<tr>
<td>• Barbershop and Salon programs – AHA, Our Ladies of Angels</td>
</tr>
<tr>
<td>o Taught how to take using digital monitors, referral mechanism back to ER, provider, etc.</td>
</tr>
<tr>
<td>o Showing or creating the best place to measure blood pressure</td>
</tr>
<tr>
<td>o Importance of medications</td>
</tr>
<tr>
<td>o Posters and resources</td>
</tr>
<tr>
<td>• Reassess how blood pressure is being measured</td>
</tr>
<tr>
<td>• HTN Management – quality checks, FQHC</td>
</tr>
<tr>
<td>o EHS – Energy</td>
</tr>
<tr>
<td>• Providers have walk in appointments am and pm;</td>
</tr>
<tr>
<td>• One clinic is going to try a half a day on Saturday</td>
</tr>
</tbody>
</table>

## Describe Successes that resulted.

## Describe Challenges/Barriers you've encountered.

## Describe Resources you are able to share.

| How we are accessing hypertension in the first place |
| AMA Target BP training – check list on proper BP measurements |
| Target BP.org numerous resources |
| Meds to Beds - Pharmacy in house |
| Patient Assistance next works |
| Translatable Resources |
| Chelsea Moreau – AHA |
| Initiatives – get persons in before their meds run out |
| Continuing education – provider meetings |
| Level sets |
| Well Ahead Resource Guide – great tool, can’t praise enough |
  | Assess our communities and see why you need to be included and heard |
| Know Diabetes by Heart, can implement a Target BP time program in your clinic |

## ALIGNMENTS / CONNECTIONS
*Where can we support each other? What alignments and connections across our organizations do we want to pursue?*
Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners
Working Together in Louisiana – September 25, 2019

- Pharmacists – interested in self-help / engagement for their patients of chronic diseases
- Connecting pharmacy and primary care – writing collaborative practice agreements
- Medication therapy management practice agreement – Pharmacists alert physician RX did not get filled.
- Physician can run a report and follow-up.
- Insurance is now following up
- Clinical Decision Supports – EHR can do a lot for your practice, great reports by Athena
Automated triggers, project ECHO coming to Louisiana.

Out of the University of Mexico – rural health clinic providers, NP, PC, sending their complicated diabetics to specialty based upon the payment structure, lack of knowledge and training, uses other allied health professionals to provide a virtual - similar to grand rounds when in med school, those engaged in online training, can have the cardiologist may recommend how a primary care provider can treat their patients, make those clinical decisions to not have to refer out.

- Getting to a specialty provider – patients must wait a long time –
- Tool – can expand to multiple topics
Working with patient navigators or community health workers?

What can we do next and how can we work together?

- Webinar during lunch time frame and with meals
- Training – disease process updates – CEU’s – more provider engagement

What is needed – works in IT Department – case management point of view, back to their provider.

- Have you kept your appointment, what barriers do you have?
- Patient Navigator (staff)
- CQM data

NEXT STEPS (TAKING ACTION AND SUSTAINING MOMENTUM)

WHAT DO WE DO NEXT? HOW DO WE KEEP THE EFFORT MOVING AND GET RESULTS?

- Identify the resources and make sure providers get them and use them
- Provider as the speaker/trainer
- Identify opportunities to use EHR data to support hypertension control
- Elevate the value of CHW/patient navigation
- Provider and system score cards increase accountability

WORKGROUP TEAM ROSTER

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Email Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea Moreau</td>
<td>American Heart Association</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latraiel Courtney</td>
<td>Well Ahead Louisiana</td>
<td><a href="mailto:Latraiel.Courtney@LA.GOV">Latraiel.Courtney@LA.GOV</a></td>
<td></td>
</tr>
<tr>
<td>Melissa Martin</td>
<td>Well Ahead Louisiana</td>
<td><a href="mailto:Melissa.R.Martin@la.gov">Melissa.R.Martin@la.gov</a></td>
<td></td>
</tr>
<tr>
<td>Julie Harvill</td>
<td>American Heart Association</td>
<td><a href="mailto:Julie.harvill@heart.org">Julie.harvill@heart.org</a></td>
<td></td>
</tr>
</tbody>
</table>
Group 2: Self Measured Blood Pressure Monitoring Programs and Clinical Supports

**Activities/Resources**
**What is each organization doing? What’s working? What isn’t? What resources can be shared?**

Describe Strategies/Approach employed for Self-measured blood pressure monitoring with clinical support:
Patient monitoring of blood pressure at home or elsewhere with clinical support including training on use of BP monitor, tracking home BP reading and guidance as needed.

- Prepare the care team to support SMBP (e.g., train staff on proper blood pressure measurement, identify staff to provide clinical support, implement standardized treatment protocols).
- Select and incorporate clinical support systems to track BP readings
- Empower patients to monitor their blood pressure (selecting the “right” monitor, taking accurate measurements, tracking measurements, providing access to monitor if needed)

Describe Successes that resulted.
1. Community Health Workers
2. Operationalizing initiatives through Cohorts instead of Individuals
3. Barbershop Initiatives
4. Champions (Community and Clinic-based)
5. Incentives
6. BP Cuff Loaner Programs

Describe Challenges/Barriers you’ve encountered.
1. Sustainability
2. Bandwidth to Implement (Time Overall)
3. Clinical Support and Care Team Resources
4. Blood Pressure Cuffs
5. Easy Online Access in ALL Communities

Well Ahead Louisiana – Need a champion to be present in the community is very important. They must check in and make sure everything is running smoothly and help where necessary. Vision is to work in Barber Shops and expand work to non-profit and faith-based organizations; councils on aging.
**Challenge:** Gaining clinical support at the beginning of the project. The community can be ready, but the clinical support side may not be. Tooling people to be best ambassadors possible. But can have all the community support, but without the clinical support, won’t work.

Questions: How do we remove the barriers to clinical support and help them? Need capacity in the clinic to do education. How to get them the resources they need?

Bunkie General Rural Health Clinics - Working with pharmacists on SMBP to be the blood pressure check point. Getting machines to home health care workers, hospitals, pharmacists. Two, pharmacies, 1 church, and the Council on Aging have contributed BP cuffs.

**Challenge:** Getting BP cuffs to those who need them Dr. Alonso recommended getting cuffs donated by a manufacturer. SpaceLabs, SunTech; Omron are manufacturers interested in helping. Can also get newer instruments they want to test – already validated, but not enough testing conducted yet. He also suggested applying for AHA innovation grants or other funding institutions for devices.

**Challenge:** How to increase patient compliance with monitoring? Patients may not have access to the resources to do so – transportation, cuffs, etc.

**Challenge:** How to get physicians in hospitals to take the actions necessary. How do you get them the time they need to support the program?

Parish Health Units– standardizing screenings; got lots of engagement; new guidelines released same timeframe, but high reading from health units not confirmed when referred to personal physician– may have been a one-time spike, using old guidelines, or other. Empowering patients.

Utilize telemedicine (from Tulane) to train providers or others to take BP. Can contact them to get the training.

Patient education on AHA site – target BP – how to take BP, but not hands on. AHA also has blood pressure booklets to track readings. AHA resources are great; easy to understand; shows what to do; what happens with undiagnosed hypertension. Patient education materials good resource too – easy to relay messaging to the barbershops. Patients began to tell the nurses and doctors how to do it.

**Challenge–** not having enough bandwidth to implement. FQHC with LSU medicine partner to meet the need and meet the patients where they are. Certintell offered remote patient monitoring program.

Empower to Serve Curriculum modified to create community ambassadors that are culturally relevant. Input and feedback on what would resonate with peers. Community Health Ambassadors run a 10-month program of classes and they follow up with participants who don’t come. Grant funded through AstraZeneca. Can you provide an incentive to get them to come? i.e voucher for a free haircut to come to the barbershop talk.

Other incentives that work – water bottles, key chains, competitions with barbershops who get the most screened. Could work on clinical side; who is doing the best job of promoting...bragging rights.

Healthcare in the clinics is changing. Documentation, preventative, quality of care – big challenge for the nurses in the clinics. Inundated with change clinics struggling with referrals. Referrals for Cessation – as an example; some docs follow through; some don’t. Trying to do an online process through QuitLine, but patient must be willing and ready to quit. And there is a cost to it.
Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners
Working Together in Louisiana – September 25, 2019

Stories to illustrate the cost of not adopting healthy lifestyle. Example of African American male smokers. They don’t go to the doctor. Needed Non-traditional cessation practices. Positive reinforced messages. Didn’t know about Quitline or free resources available. Takes time to educate them about risks, resources. Phase 2 – make the ask – to get them to quit. Trained tobacco consultants; job centers, faith-based centers, etc – non-traditional spaces.

- Prepare the care team to support SMBP (e.g., train staff on proper blood pressure measurement, identify staff to provide clinical support, implement standardized treatment protocols).
- Select and incorporate clinical support systems to track BP readings
- Empower patients to monitor their blood pressure (selecting the “right” monitor, taking accurate measurements, tracking measurements, providing access to monitor if needed)

Describe Resources you are able to share.
1. Million Hearts; AHA; AMA
2. Barbershop Toolkits (and other Toolkits)
3. Donations from Spacelabs, Omron and Suntech for cuffs
4. Tulane Telemedicine Training on SMBP (FREE) Can be done Virtually or Face to Face
5. Utilizing Community Partners such as Pharmacies, Councils on Aging, Job Centers and Faith Based Institutions

ALIGNMENTS / CONNECTIONS
Where can we support each other?
What alignments and connections across our organizations do we want to pursue?

This group develops training for Community health workers; educating about chronic diseases. (Medicaid can provide reimbursement for but need certain certifications, etc. – large undertaking)
Identify, Train and Deploy Community Health Workers (Healthy Heart Beat Ambassadors, Practice Coaches, LaCHON)

Population health dynamics are growing in importance. Chronic care management is coming. Someone has to figure it out. Need continuity to work on it. Meet regularly to keep the ball rolling. Bigger health system groups will start coming together.

Can we tap AMA training if we have enough numbers? Rural population health cohort – programmatic umbrella through Dept of Health.

Toolkit for Louisiana on how to implement SMBP in your area.

Join the SMBP Forum that is part of Million Hearts.

Healthcarecommunities.org SMBP community within. By the National Association of Community Health Centers. Different resources for different audiences. Can be looking for models.

Promote Telemedical Initiatives
Provide Universal Training (specifically to Population Health Cohort) Please note that going forward, AMA-led practice facilitation will be available only for healthcare organizations serving over 100,000 adult patients with hypertension.
**NEXT STEPS (TAKING ACTION AND SUSTAINING MOMENTUM)**

*What do we DO Next? How do we keep the effort moving and get results?*

- Connect with Obesity Commission – initiate/create BP Sub-Committee or Hypertension Advisory Council
- Well-Ahead to put together a Statewide toolkit with resources for training and information on how to get funding
- Engage Payers | Insurers to pay for blood pressure cuffs or provide at no cost
- Medicaid Reimbursement services for Community Health Workers
- Touch – Communicate – Outreach

Create network for region
Determine how to pursue Medicaid reimbursement
Group should meet monthly or bi-weekly
Well ahead is putting together a list of resources
Develop initiatives and trainings
What is the sustainable infrastructure to support the work through Well ahead obesity commission? or other channels.

**To Do for All:** Join SMBP Forum (Million Hearts to send link) and healthcarecommunities.org for the most up-to-date info.

---

**WORKGROUP TEAM ROSTER**

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Email Address</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coretta LaGarde</td>
<td>AHA</td>
<td><a href="mailto:coretta.lagarde@heart.org">coretta.lagarde@heart.org</a></td>
<td></td>
</tr>
<tr>
<td>Danelle Guillory</td>
<td>Sankofa</td>
<td><a href="mailto:danelle@sankofanola.org">danelle@sankofanola.org</a></td>
<td></td>
</tr>
<tr>
<td>Kaitlyn King</td>
<td>Well-Ahead</td>
<td><a href="mailto:kaitlyn.king@la.gov">kaitlyn.king@la.gov</a></td>
<td></td>
</tr>
<tr>
<td>Kelly Flaherty</td>
<td>AHA</td>
<td><a href="mailto:kelly.flaherty@heart.org">kelly.flaherty@heart.org</a></td>
<td></td>
</tr>
<tr>
<td>Sharon Nelson</td>
<td>AHA</td>
<td><a href="mailto:sharon.nelso@heart.org">sharon.nelso@heart.org</a></td>
<td></td>
</tr>
<tr>
<td>Marsha Gauthier</td>
<td>Bunkie General Rural Health Clinics</td>
<td><a href="mailto:marshag@bunkiegeneral.com">marshag@bunkiegeneral.com</a></td>
<td></td>
</tr>
<tr>
<td>Camilo Fernandez</td>
<td>Tulane</td>
<td><a href="mailto:cfern1@tulane.edu">cfern1@tulane.edu</a></td>
<td></td>
</tr>
<tr>
<td>Marie Darr</td>
<td>Well-Ahead</td>
<td><a href="mailto:marie.darr@la.gov">marie.darr@la.gov</a></td>
<td></td>
</tr>
<tr>
<td>Marcy Hubbs</td>
<td>Well-Ahead</td>
<td><a href="mailto:marcy.hubbs@la.gov">marcy.hubbs@la.gov</a></td>
<td></td>
</tr>
<tr>
<td>Becky Wilkes</td>
<td>Well-Ahead</td>
<td><a href="mailto:rebecca.Wilkes@la.gov">rebecca.Wilkes@la.gov</a></td>
<td></td>
</tr>
<tr>
<td>Bridgette Bienville</td>
<td>Louisiana Primary Care Association</td>
<td><a href="mailto:bbienville@lpca.net">bbienville@lpca.net</a></td>
<td></td>
</tr>
<tr>
<td>Tonia Moore</td>
<td>Louisiana Public Health Association</td>
<td><a href="mailto:tmoore@lphi.org">tmoore@lphi.org</a></td>
<td></td>
</tr>
</tbody>
</table>
Group 3: Clinical-Community Partnerships for Hypertension Management

ACTIVITIES / RESOURCES
What is each organization doing? What’s working? What isn’t? What resources can be shared?

Describe Strategies/Approach employed for Clinical-community partnerships for hypertension management:
Connecting community programs with health systems to improve chronic disease prevention, care, and management.
- Working with community partners to provide self-management support and education
- Engaging Community Health Workers in the health care team
- Working with pharmacists to provide Medication Therapy Management
- Implementing referral systems and tracking patient participation in lifestyle change programs

Describe Successes that resulted.
MCO is really focused on NQF18. They have a number of quality measures that the SHD holds the MCO accountable for. If BP became more of a policy focus, it would trigger more activity.

How do we educate SNAP benefits how to cook healthy foods and how to pick out healthy foods?

Community education
- SNAP “buy this, not that”
- School-based events/gardens
- Resources

Leverage existing community partnerships
Community benefit dollars- where is the 340B dollars going; hospitals need education on where to invest these funds especially on social determinants of health. A lot of opportunity to provide input as the hospital is planning.

Tobacco cessation resources for the quitline

Describe Challenges/Barriers you've encountered.
HTN needs more of a state focus on the policy level- state accountability in contracts?

Every community in LA is so different so even though there could be an overarching healthy foods policy in the state it would be different in every community.

Challenges with referral to quitline given high cost. There should be a referral in the EHR system and there are a lot of systems and there were a lot of challenges. They do fax to quit but a lot of clinics are no longer using fax. We don’t want to create a system just for cessation/quitline if there is an opportunity to unite with another initiative.
1. Community needs to know what resources are available-does the community have the resources to begin with
2. They need to be able to be able to access a physician or CHW that can refer them-linking to the resources

ALIGNMENTS / CONNECTIONS
Where can we support each other?
What alignments and connections across our organizations do we want to pursue?
Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners
Working Together in Louisiana – September 25, 2019

- Value in hyper targeted work groups
- What is the best system to capture resources in a community.
- Local community level-Which ones work best
- LSU AG-gap analysis
- Q10-QIN coalition meetings
- Chamber of Commerce-how to push activities into the community
- Coalition lenders

How do we unite to find discretionary dollars for the programs we need rather than be given money for prescribed programs?
For ex- SSB tax can’t be taxed on an even year and locals are preempted to do it themselves.
Well Ahead Obesity, Diabetes and Tobacco Coalitions- should we combine to develop a Chronic Disease Collaborative and also include HTN since they involve similar partners

**NEXT STEPS (TAKING ACTION AND SUSTAINING MOMENTUM)**
*What do we DO Next? How do we keep the effort moving and get results?*

Action Items- Explore Obesity Commission- can we make the group actionable by adding HTN as a focus-
• LDH will lead; AHA (Ashley) to back up

Increased communication amongst us
Hyper focused workgroups
Greater understanding of what’s happening and what’s needed- attend local coalitions needed
Linking partners to Quality Systems training
Community assessment to identify GAPS- LSU maps
Chamber of Commerce engagement
Engage Coalition Leaders and find a way to communicate with them
• Louisiana Healthy Community Coalitions
• Rapides Foundation

**WORKGROUP TEAM ROSTER**

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Email Address</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colleen Arceneaux</td>
<td>Well- Ahead Louisiana</td>
<td><a href="mailto:Coleen.Arceneaux@la.gov">Coleen.Arceneaux@la.gov</a></td>
<td></td>
</tr>
<tr>
<td>Brian Burton</td>
<td>Southwest Louisiana Area Health</td>
<td><a href="mailto:ceo@swlahec.com">ceo@swlahec.com</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Education Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashley Hebert</td>
<td>American Heart Association</td>
<td><a href="mailto:Ashley.Hebert@heart.org">Ashley.Hebert@heart.org</a></td>
<td></td>
</tr>
<tr>
<td>Erin Leonard</td>
<td>Well- Ahead Louisiana</td>
<td><a href="mailto:Erin.Leonard@la.gov">Erin.Leonard@la.gov</a></td>
<td></td>
</tr>
<tr>
<td>Julia Schneider</td>
<td>National Association of Chronic</td>
<td><a href="mailto:jschneider@chronicdisease.org">jschneider@chronicdisease.org</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disease Directors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bryan Hanaki</td>
<td>Louisiana Healthcare Connections</td>
<td><a href="mailto:bryan.m.hanaki@louisianahealthconnect.com">bryan.m.hanaki@louisianahealthconnect.com</a></td>
<td></td>
</tr>
<tr>
<td>Hobie Fluitt</td>
<td>Well- Ahead Louisiana</td>
<td><a href="mailto:Hobie.Fluitt@la.gov">Hobie.Fluitt@la.gov</a></td>
<td>337-581-4140</td>
</tr>
<tr>
<td>Audrey Shields</td>
<td>Well- Ahead Louisiana</td>
<td><a href="mailto:Audrey.Shields@la.gov">Audrey.Shields@la.gov</a></td>
<td>228-669-3265</td>
</tr>
<tr>
<td>Hillary Sutton</td>
<td>Well- Ahead Louisiana</td>
<td><a href="mailto:Hillary.Sutton@la.gov">Hillary.Sutton@la.gov</a></td>
<td>225-342-0935</td>
</tr>
</tbody>
</table>
## Attendee List:

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Organization</th>
<th>Title</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robin</td>
<td>Rhodes</td>
<td>Well-Ahead Louisiana</td>
<td>Director</td>
<td><a href="mailto:Robin.Rhodes@la.gov">Robin.Rhodes@la.gov</a></td>
</tr>
<tr>
<td>Emily</td>
<td>Soileau</td>
<td>Opelousas General Health System</td>
<td>Director</td>
<td><a href="mailto:emilysoileau@opelousasgeneral.com">emilysoileau@opelousasgeneral.com</a></td>
</tr>
<tr>
<td>Taylor</td>
<td>Reine</td>
<td>Well-Ahead Louisiana</td>
<td>Director</td>
<td><a href="mailto:Taylor.Reine@la.gov">Taylor.Reine@la.gov</a></td>
</tr>
</tbody>
</table>

---

**Attendee List Details:**

- **Julia Schneider**, National Association of Chronic Disease Directors, Consultant, Cardiovascular Health: jschneider@chronicdisease.org
- **John Clymer**, National Forum for Heart Disease & Stroke Prevention, Executive Director: john.clymer@nationalforum.org
- **Courtney Sanford**, Louisiana Primary Care Association, Clinical Quality Coordinator: csanford@lpcanet.com
- **Coretta LaGarde**, American Heart Association, Vice President of Health Strategies: coretta.lagarde@heart.org
- **Sharon Nelson**, American Heart Association, Program Initiatives Manager: sharon.nelson@heart.org
- **Jasmine Breaux**, Baton Rouge Primary Care Collaborative, Inc., Chief Executive Officer: sblank@brprimarycare.org
- **Stacie Bland**, Baton Rouge Primary Care Collaborative, Inc., Family Nurse Practitioner: stbland@brprimarycare.org
- **Trish Erwin**, Bunkie General Rural Health Clinics, Registered Nurse: trisherwin@bunkiegeneral.com
- **Marsha Gauthier**, Bunkie General Rural Health Clinics, Registered Nurse: marshag@bunkiegeneral.com
- **Veronica Gillispie-Bell**, Louisiana Department of Health, Medical Director, LAPQC and PAMR: veronica.gillispie@la.gov
- **Marsha Nelson**, Bunkie General Rural Health Clinics, Registered Nurse: marshag@bunkiegeneral.com
- **Cindy Boykin**, Opelousas General Health System, Director of Population Health: cboykin@opelousasgeneral.com
- **Jasper Sands**, Opelousas General Health System, Director of Community Relations: jsands@opelousasgeneral.com

---

**Contact Information:**

- **Robin Rhodes**
  - Phone: 225-342-9307
  - Email: Robin.Rhodes@la.gov

---

**Additional Resources:**

- [Opelousas General Health System](http://www.opelousasgeneral.com)
- [Well-Ahead Louisiana](http://www.well-ahead.org)
- [American Heart Association](http://www.heart.org)

---

**Notes:**

- This list includes key attendees from various organizations involved in heart disease and stroke prevention initiatives in Louisiana.
- The contact information provided includes names, titles, and email addresses for effective communication.
- The phone number 225-342-9307 belongs to Robin Rhodes, the Well-Ahead Louisiana Director.

---

**Footer:**

**Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners**

**Working Together in Louisiana – September 25, 2019**
Advancing Million Hearts®:
AHA and State Heart Disease and Stroke Partners Working Together in Louisiana

September 25, 2019 – 8:30 AM to 3:00 PM Central
Louisiana State University – Lod Cook Alumni Center
3838 West Lakeshore Drive
Baton Rouge, Louisiana

8:30 am – Networking
9:00 am – Meeting Starts

Welcome and Opening Remarks

JOHN CLYMER
Executive Director
National Forum for Heart Disease and Stroke Prevention
Co-chair, Million Hearts® Collaboration

Purpose and Outcomes

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 and identify strategies for Million Hearts® priorities.

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®.


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

Introductions

JOHN BARTKUS
Principal Program Manager
Pensivia

Alignment

• "We’re all Arrows"
• Look around the room. Identify something to focus on.
• Close your eyes. Fully extend your arm to point at it. (Watch out for your neighbors)

Overview of the Day

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

Agenda

• Welcome & Overview of the Day
• Introductions
• Million Hearts® 2022 Update
• Louisiana Department of Health/Accelerate initiatives
• Quality Insights, Quality Innovation Network
• Million Hearts® in Action (2013-2019)
• Local and State Hypertension Collaboratives
• Hypertension Care-Achieving Organizational Standards
• Louisiana Hypertension Self-Certification
• Specialty Committees: Development/Support
• Rural Heart Disease and Stroke Prevention Programs
• Lunch @ 12:00 noon
• Facilitated Discussions / Breakouts (3)
• Group Report Outs and Next Steps
• Evaluation and Feedback Process
• Wrap up / Adjourn
Alignment and Connections

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

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

Alignment and Connections

Leverage your Partner Profiles which came from the pre-meeting questionnaire.

Alignment

Coordination of Purpose, Focus and Energy

Higher Impact on the target

15 Second Introductions

Name & Organization

“One thing I want from today is ...”
(One Sentence)

Million Hearts® 2022 Overview and Update

TIFFANY FELL
Deputy to Associate Director
Policy, External Relations, and Communications Office
Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention

Overview and Update

Million Hearts® 2022

Aim: Prevent 1 million—or more—heart attacks and strokes by 2022
- National initiative co-led by:
  - Centers for Disease Control and Prevention (CDC)
  - Centers for Medicare & Medicaid Services (CMS)
  - Partners across federal and state agencies and private organizations

Tiffany Fell
Deputy Associate Director, PERC
Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention

Preventing 1 Million Heart Attacks and Strokes by 2022

10/11/2019
I changed the last sentence of the notes to be more in line with Louisiana's program (old Utah sliddeck)
Stokfisz, Andrea (CDC/DDNID/NCCDPHP/DHDSP) (CTR), 9/23/2019
• More than 1.5 million people in the U.S. suffer from heart attack and stroke per year.
• More than 800,000 deaths per year in the U.S. from cardiovascular disease (CVD).
• CVD costs the U.S. hundreds of billions of dollars per year.
• CVD is the greatest contributor to racial disparities in life expectancy.

Heart Disease and Stroke in the U.S.

Heart Disease and Stroke Trends 1950–2015

- Parish-level death rates

What this means for Louisiana

- We project 279,300 “Million Heartspreventable events” that will occur in LA if we do nothing.
- 6% reduction of those events = 16,800 events we hope LA will prevent.

Keeping People Healthy

Optimizing Care

Parish-level death rates

Million Hearts® 2022 Priorities

Improving Outcomes for Priority Populations
Million Hearts® Resources and Tools

- Action Guides —Hypertension control; Self-measured blood pressure monitoring (SMBP); Tobacco cessation; Medication adherence
- Protocols —Hypertension treatment; Tobacco cessation; Cholesterol management
- Tools —Hypertension prevention motivation; ASCVD risk

Messages and Resources —Undiagnosed Hypertension, Medication Adherence, Health IT, SMBP, Particle Pollution, Physical Activity, Tobacco Use

Clinical Quality Measures

Consumer Resources and Tools

Million Hearts® 2022 Website: https://millionhearts.hhs.gov/

Tobacco Cessation Change Package (TCCP)

Access the Change Package at: https://millionhearts.hhs.gov/files/Tobacco_Cessation_Change_Pkg.pdf

Million Hearts® in Municipalities Toolkit

Hypertension Control Change Package

Recognize hospitals working systematically to improve the cardiovascular health of the populations they serve by:
1. Keeping People Healthy
2. Optimizing Care
3. Improving Outcomes for Priority Populations
4. Innovating for Health

• Applicants must address a minimum of one strategy in at least three of the four priority areas

Application Process

Applicants can be recognized for — committing, implementing, or achieving — for each strategy they intend to address:
- Committing — no data required other than your commitment to implement
- Implementing — must submit the data per strategy listed as “Required attestation for those implementing”
- Achieving — must submit the data per strategy listed as “Recommended outcomes for those achieving results”

Million Hearts® for Clinicians Microsite

Features Million Hearts® protocols, action guides, and other QI tools

 Syndicates LIVE Million Hearts® on your website for your clinical audience

Requires a small amount of HTML code—customizable by color and responsive to layouts and screen sizes

Content is free, cleared, and continuously maintained by CDC

Available at https://tools.cdc.gov/medialibrary/index.aspx#/microsite/id/279017

Stay Connected

- Million Hearts® e-Update Newsletter
- Million Hearts® on Facebook and Twitter
- Million Hearts® Website
- Million Hearts® for Clinicians Microsite

Million Hearts® SMBP Forum

- Meets quarterly to facilitate the exchange of SMBP best practices, ideas, and resources
- Join the SMBP Forum at https://www.nachc.org/MillionHeartsSMBP

Access materials via the SMBP Healthcare Community

- Go to www.healthcarecommunities.org and log in to your account
- Search for ‘SMBP’ under the ‘Available Communities’ tab
- Click “Join Community”

Questions: MillionHeartsSMBP@nachc.org

Stay Connected

- Million Hearts® e-Update Newsletter
- Million Hearts® on Facebook and Twitter
- Million Hearts® Website
- Million Hearts® for Clinicians Microsite
Louisiana Department of Health Hypertension Initiatives

MELISSA R MARTIN, RDN, LDN
Well-Ahead Louisiana Director

Connecting Louisiana Residents to a Healthier Future

- State Office of Rural Health
- Medicare Rural Hospital Flex
- Rural Hospital Improvement Program
- State Loan Repayment Program
- Primary Care Office
- HPSA Designation
- State Refugee Program
- Early Care and School Health Promotion
- Obesity and Management Prevention
- Diabetes Management and Prevention
- Heart Disease Management and Prevention
- Tobacco Cessation and Prevention
- WellSpot Designation
- Healthy Community Design

Louisiana Data

Prevalence of high blood pressure amongst adults (18yrs and above)

<table>
<thead>
<tr>
<th>Parish</th>
<th>Prevalence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITE NON HISPANIC</td>
<td>40.4</td>
</tr>
<tr>
<td>BLACK NON HISPANIC</td>
<td>37.8</td>
</tr>
</tbody>
</table>

% Population ever told they have high blood pressure

- 37%
- 38%
- 39%
- 40%
- 41%
- 42%
- 43%

Prevalence of high blood pressure amongst adults, 18yrs and above

- 18-24 YRS
- 24-34 YRS
- 35-44 YRS
- 45-54 YRS
- 55-64 YRS
- 65+ YRS

Prevalence of high blood pressure amongst adults, 18yrs and above

- MALE
- FEMALE
Well-Ahead Heart Disease Prevention and Management

Public Health Approach: Policy, System, Environmental Change

- **Policy**
  - Interventions that create or amend laws, ordinances, resolutions, mandates, regulations, or rules.
- **System**
  - Interventions that impact all elements of an organization, institution, or system.
- **Environmental**
  - Interventions that involve physical or material changes to the economic, social, or physical environment.

Stay Connected

Bookmark www.walpen.org
The QIN-QIO Program’s Approach to Clinical Quality

**Aims**

- Make care safer
- Strengthen person and family engagement
- Promote effective communication and coordination of care
- Promote effective prevention and treatment
- Promote best practices
- Make care affordable

**Foundational Principles**

- Enable innovation
- Foster learning organizations
- Eliminate disparities
- Strengthen infrastructure and data systems

**Four Key Roles of QIN-QIOs**

- Facilitate learning and Action Networks (LANs)
- Teach and advise as technical experts
- Champion local-level, results-oriented change
  - Improve data
  - Active engagement of patients; convene community partners
  - Spread innovation and best practices that “stick”
- Communicate effectively
  - Sustain initiatives, prevention and patient/family behavior change

**CMS 2014-2019 Medicare Quality Improvement Projects**

- Cardiovascular Health
- Nursing Home Quality
- Quality Reporting and Payment
- Readmissions
- Adult Immunizations
- Palliative Care and Hospice Referrals for Heart Failure Patients
- Quality Improvement in ICFs
- Transforming Clinical Practice
- Antibiotic Stewardship
- Preventing Adverse Drug Events
- RAISE with Diabetes Care Teams
- Spinal Cord Injury
- Annual Wellness Visit

**Hypertension focus**

- Cardiovascular Health
- Directives - Stroke prevention, HTN and smoking cessation
- Promoted Million Hearts website, best practices, resources
- Developed/promoted Quality Insights resources specific to stroke & BP
- Innovative resource distribution to beneficiaries through food commodity boxes in rural areas, Meals on Wheels

**Hypertension focus**

- Diabetes Self Management Program
  - Taught DEEP curriculum that included:
    - Cardiac overview
    - BP normal and HTN parameters
    - Nutrition and exercise effects on BP
    - Proper BP cuff placement
    - Tips for BP home readings, monitoring, reporting
    - When to call your health care provider
    - Medication adherence and reconciliation
CMS Medicare Quality Improvement Projects on the Horizon

5 Broad Aims

1. Improve Behavioral Health Outcomes, focusing on Decreased Opioid Misuse:
   - Decrease opioid-related deaths and adverse drug events by 7% nationally
   - Decrease opioid prescribing for Rx >/90mg/day
   - Provide community education regarding HHS Opioid Strategies

2. Increase Patient Safety:
   - Reduce ADEs in all settings by 6.5% nationally
   - Reduce ADEs in NH by 13% nationally

3. Increase Chronic Disease Self-Management
   - Cardiac and Vascular Health
   - Diabetes
   - Slowing and preventing ESRD

4. Increase Quality of Care Transitions
   - Decrease ED super utilizers by 12.24%

5. Improve Nursing Home Quality
   - Reduce ADEs by 15.2%
   - Improve mean total quality scores by 11%

Questions

American Heart Association Hypertension Initiatives

ASHLEY HEBERT, MPA
Government Relations Director
Louisiana

CORETTA LAGARDE
Vice President, Health Strategies
Louisiana

Trends in health improvements:

- Part of the 2020 impact goal is to improve health by 20%, and to remove and/or control 40%
- In adults, we are seeing improvements in smoking rates, healthy diet, physical activity, blood pressure, cholesterol and blood glucose.
- In adults, we are improving in existing risks, healthy diet, and smoking cessation.
- In adults, we are improving in existing risks, healthy diet, and smoking cessation.
- In adults, we are improving in existing risks, healthy diet, and smoking cessation.
- In adults, we are improving in existing risks, healthy diet, and smoking cessation.

Who we are:
The American Heart Association / American Stroke Association is not just a charity. We are researchers, innovators, scientists and partners.

Our Mission:
To be a relentless force for a world of longer, healthier lives.
Building a culture of health in the community

Spotlight on Louisiana
Get with the Guidelines & Mission: Lifeline Quality Awards

State Campaigns
Healthy Restaurant Kids’ Meals: Sugary drinks are the single largest source of added sugars consumed by people living in the United States. Sugary drinks also increase the risk of hypertension and heart disease, independent of weight gain. Increasing sugary drink consumption by one serving per day can increase a person’s risk of hypertension by eight percent and risk of heart disease by 17 percent.

Improving Health

Americans have high blood pressure.

Nearly 86 million People have participated in Check. Change. Control. program to lower their blood pressure.

Our goal is to move Americans to healthier cholesterol levels by 2020.

You’re the Cure – Advocacy

Through our advocacy efforts:

- 3.8 million babies are screened for congenital heart defects.
- 2.0 million Americans live in smoke-free communities.
- 2.5 million students are trained in CPR every year.

Local Campaigns

New Orleans Complete Streets: The New Orleans Complete Streets Coalition had a productive meeting with Mayor Cantrell and key members of her staff this week. Her team will provide a response to the Complete Streets policy recommendations we provided by September 1st. In addition, the Mayor will reconvene the Complete Streets Working Group meetings.

New Orleans Healthy Restaurant Kids’ Meals: We met with City Council members and the City’s Health Department in moving toward an ordinance that would provide for water and milk as the default beverage for kids’ meals at local restaurants. We have a clear path forward for this policy, so stay tuned!

Smoke Free Lake Charles: The Coalition for a Tobacco-Free Louisiana (CTFLA) has begun grassroots activities in Lake Charles and kicked off the football season right with a smoke-free tailgate for the Southern University vs. McNeese game. Having volunteer-based support, especially from the business community, to push council members to consider a smoke free ordinance is imperative.

Know Diabetes By Heart

We’re working alongside the American Diabetes Association and other partners to increase awareness. 32 million adults have diabetes, including 3 million with undiagnosed.

Annually, more than 30 million Americans have diabetes, including 7.2 million who are undiagnosed.

Cardiovascular disease is the leading cause of death for people living with type 2 diabetes.

Spotlight on Louisiana
Advocacy – Policy Priorities in Louisiana

Healthy Eating / Active Living

Healthy Eats, Active Lives: Support efforts to increase active living and healthy eating through policy

Tobacco Free

You’re the Cure – Advocacy

Support efforts to decrease tobacco use in Louisiana

Local Campaigns

Smoke Free Shreveport: Stay tuned for an Advocacy training on comprehensive smoke-free policies, including common tobacco and casino industry tactics.

Smoke Free Lake Charles: The Coalition for a Tobacco-Free Louisiana (CTFLA) has begun grassroots activities in Lake Charles and kicked off the football season right with a smoke-free tailgate for the Southern University vs. McNeese game. Having volunteer-based support, especially from the business community, to push council members to consider a smoke free ordinance is imperative.
Tools and Resources

Online Tools
- AHA Louisiana Facebook Page: https://www.facebook.com/AHA.louisiana/
- My Life Check
- Heart Attack risk Calculator
- AHA's Tarascon Emergency Card and Resources
- AHA's Workplace Health Solutions

Resources
- EmPowered to Serve
- Get With The Guidelines: www.heart.org/gwtg
- Target: BP
- American Heart Association: www.americanheart.org

Discussion
1. Is there a program you are 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?

Louisiana Partner Hypertension Initiatives

Kenny J Cole, MD, MHCDS
System VP, Clinical Improvement
Ochsner Health System

Partnering with Providers to Implement Sustainable Systems Changes

Contact Information
Coretta LaGarde
Coretta.Lagarde@heart.org

Ashley Hebert
Ashley.Hebert@heart.org

Life in Louisiana

Resume at 10:45 am

Louisiana's Cardiovascular Crisis

- Measurable improvements in high blood pressure prevention, detection, and control
- 80% of patients at goal according to JNCVII
- 75% of AMGA membership adopt (at least one) campaign planks
- Engage and empower patients in achieving measurable health goals
80% of Patients at Goal Blood Pressure

Processes to Achieve Goal

- Direct Care Staff trained in accurate BP measurement
- Registry used to identify and track hypertension patients
- All specialties intervene with patients not in control
- All team members trained in importance of BP goals
- 91 BP addressed for every hypertension patient, every primary care visit

Evidence-Based Protocol
- Includes key steps in measurement, goals, ancillary testing, life style modifications, and patient engagement strategies
- Flows path to medication prescription and follow up visits based on how far BP is out of control
- Identifies additional tests for treatment resistant hypertension
- Lists drug names, dosages, and notes by medication category for both mono therapy and combination therapy

Registry of Uncontrolled Patients

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Race</th>
<th>Sex</th>
<th>BP at last visit</th>
<th>Return Visit Scheduled</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joe Smith</td>
<td>56</td>
<td>White</td>
<td>M</td>
<td>150/90</td>
<td>10/27/14</td>
<td></td>
</tr>
<tr>
<td>Jane Doe</td>
<td>62</td>
<td>Black</td>
<td>F</td>
<td>166/102</td>
<td>10/29/14</td>
<td></td>
</tr>
<tr>
<td>Mary Jane</td>
<td>58</td>
<td>White</td>
<td>F</td>
<td>162/94</td>
<td>10/16/14</td>
<td>Nurse Kim has left two messages trying to contact patient</td>
</tr>
<tr>
<td>Pat James</td>
<td>55</td>
<td>White</td>
<td>M</td>
<td>144/83</td>
<td>10/31/14</td>
<td>BP is improving. Can return for nurses visit.</td>
</tr>
</tbody>
</table>

Nursing Telephonic Outreach for Patient Engagement
- Utilized registry to contact patients about scheduling follow up visits
- Fostered patient engagement by reminding them of the importance of getting BP under control
- Allowed patients to return for a nurse visit to measure BP, avoiding costly copays

Bogalusa Heart Study and Hypertension

Camilo Fernandez Alonso, MD MS
Department of Epidemiology, Center for Cardiovascular Health
Tulane University School of Public Health and Tropical Medicine
New Orleans, Louisiana

Quality Blue Primary Care

Quality Blue Primary Care

Initial Clinical Outcomes Measures

- Heart Failure
- Cardiovascular disease
- Non-smoker
- Aspirin
- Warfarin
- Quality of Life
- Healthier Patients

Rates of Hypertension Control

- 2013: 45%
- 2017: 50%
- 2018: 55%

Evidence-Based Protocol
- Includes key steps in measurement, goals, ancillary testing, life style modifications, and patient engagement strategies
- Flows path to medication prescription and follow up visits based on how far BP is out of control
- Identifies additional tests for treatment resistant hypertension
- Lists drug names, dosages, and notes by medication category for both mono therapy and combination therapy

Registry of Uncontrolled Patients

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Race</th>
<th>Sex</th>
<th>BP at last visit</th>
<th>Return Visit Scheduled</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joe Smith</td>
<td>56</td>
<td>White</td>
<td>M</td>
<td>150/90</td>
<td>10/27/14</td>
<td></td>
</tr>
<tr>
<td>Jane Doe</td>
<td>62</td>
<td>Black</td>
<td>F</td>
<td>166/102</td>
<td>10/29/14</td>
<td></td>
</tr>
<tr>
<td>Mary Jane</td>
<td>58</td>
<td>White</td>
<td>F</td>
<td>162/94</td>
<td>10/16/14</td>
<td>Nurse Kim has left two messages trying to contact patient</td>
</tr>
<tr>
<td>Pat James</td>
<td>55</td>
<td>White</td>
<td>M</td>
<td>144/83</td>
<td>10/31/14</td>
<td>BP is improving. Can return for nurses visit.</td>
</tr>
</tbody>
</table>

Nursing Telephonic Outreach for Patient Engagement
- Utilized registry to contact patients about scheduling follow up visits
- Fostered patient engagement by reminding them of the importance of getting BP under control
- Allowed patients to return for a nurse visit to measure BP, avoiding costly copays

Bogalusa Heart Study and Hypertension

Camilo Fernandez Alonso, MD MS
Department of Epidemiology, Center for Cardiovascular Health
Tulane University School of Public Health and Tropical Medicine
New Orleans, Louisiana

Quality Blue Primary Care

Initial Clinical Outcomes Measures

- Heart Failure
- Cardiovascular disease
- Non-smoker
- Aspirin
- Warfarin
- Quality of Life
- Healthier Patients

Rates of Hypertension Control

- 2013: 45%
- 2017: 50%
- 2018: 55%
Bogalusa, Louisiana

One of the longest on-going studies of a biracial, semi-rural community in the Southern US. Our focus is on understanding the impact of cardiovascular and metabolic changes on health throughout the lifespan. 170+ studies/sub-studies have been conducted over the years, which include special studies on blood pressure studies, heart murmur studies, newborn cohort, diabetes, a lipids study, genetic/epi-genetic studies, exercise, socioeconomic evaluations, and metabolic changes on health throughout the lifespan.

Did you know.....

- Tulane University is home to one of the most pivotal research studies in the field of hypertension and cardiovascular pathology, and CV imaging.

- More than 1,000 publications, five textbooks and numerous monographs have been produced over the years, which include special studies on blood pressure studies, heart murmur studies, newborn cohort, diabetes, a lipids study, genetic/epi-genetic studies, exercise, socioeconomic evaluations, and metabolic changes on health throughout the lifespan.

**Did you know...**

- Did you know that Tulane University is home to one of the most pivotal research studies in the field of hypertension and cardiovascular pathology, and CV imaging?

- The Bogalusa Heart Study is one of the most influential studies in the field of cardiovascular disease research, with more than 1,000 publications and five textbooks to its name. The study has contributed significantly to our understanding of the development of cardiovascular disease risk factors in childhood and their impact on health in adulthood.

- The Bogalusa Heart Study began in 1972 and has followed thousands of children and adults in Bogalusa, Louisiana. Its focus is on understanding the impact of cardiovascular and metabolic changes on health throughout the lifespan.

**Major Findings by Decade**

- **1970s**: The Bogalusa Heart Study began, focusing on understanding the impact of cardiovascular and metabolic changes on health throughout the lifespan. The study was established in Bogalusa, Louisiana, and enrolled thousands of children and adults.

- **1980s**: The Bogalusa Heart Study continued to follow children and adults, with a focus on blood pressure and body weight as risk factors for cardiovascular disease. The study found that childhood levels of blood pressure and body weight predict or "track" into young adulthood and might influence mid-life health.

- **1990s**: The Bogalusa Heart Study continued to follow participants, with a focus on the role of environmental factors in cardiovascular disease. The study found that the roots of heart disease go back even into time during pregnancy, time in utero.

- **2000s**: The Bogalusa Heart Study continued to follow participants, with a focus on the role of genetic and epigenetic factors in cardiovascular disease. The study found that genes influence heart disease risk factors, suggesting that overall aging processes can be influenced by these.

- **2010s**: The Bogalusa Heart Study continued to follow participants, with a focus on the role of social determinants in cardiovascular disease. The study found that the impact of cardiovascular disease risk factors, such as blood pressure, body weight, and cholesterol, is more pronounced among disadvantaged populations.

- **2020s**: The Bogalusa Heart Study continues to follow participants, with a focus on the role of emerging technologies in cardiovascular disease. The study is pioneering the use of new technologies, such as wearable devices and electronic health records, to monitor and prevent cardiovascular disease.

**Findings by Decade (cont'd)**

- **1970s**: The Bogalusa Heart Study began, focusing on understanding the impact of cardiovascular and metabolic changes on health throughout the lifespan. The study was established in Bogalusa, Louisiana, and enrolled thousands of children and adults.

- **1980s**: The Bogalusa Heart Study continued to follow participants, with a focus on blood pressure and body weight as risk factors for cardiovascular disease. The study found that childhood levels of blood pressure and body weight predict or "track" into young adulthood and might influence mid-life health.

- **1990s**: The Bogalusa Heart Study continued to follow participants, with a focus on the role of environmental factors in cardiovascular disease. The study found that the roots of heart disease go back even into time during pregnancy, time in utero.

- **2000s**: The Bogalusa Heart Study continued to follow participants, with a focus on the role of genetic and epigenetic factors in cardiovascular disease. The study found that genes influence heart disease risk factors, suggesting that overall aging processes can be influenced by these.

- **2010s**: The Bogalusa Heart Study continued to follow participants, with a focus on the role of social determinants in cardiovascular disease. The study found that the impact of cardiovascular disease risk factors, such as blood pressure, body weight, and cholesterol, is more pronounced among disadvantaged populations.

- **2020s**: The Bogalusa Heart Study continues to follow participants, with a focus on the role of emerging technologies in cardiovascular disease. The study is pioneering the use of new technologies, such as wearable devices and electronic health records, to monitor and prevent cardiovascular disease.

**National Reach**

- The Bogalusa Heart Study has had a significant impact on cardiovascular disease research worldwide, with more than 1,000 publications and five textbooks to its name. The study has contributed significantly to our understanding of the development of cardiovascular disease risk factors in childhood and their impact on health in adulthood.

**Worldwide Reach**

- The Bogalusa Heart Study has had a significant impact on cardiovascular disease research worldwide, with more than 1,000 publications and five textbooks to its name. The study has contributed significantly to our understanding of the development of cardiovascular disease risk factors in childhood and their impact on health in adulthood.

- The Bogalusa Heart Study was established in Bogalusa, Louisiana, and enrolled thousands of children and adults. Its focus is on understanding the impact of cardiovascular and metabolic changes on health throughout the lifespan.

- The Bogalusa Heart Study has contributed significantly to our understanding of the development of cardiovascular disease risk factors in childhood and their impact on health in adulthood.

- The Bogalusa Heart Study has contributed significantly to our understanding of the development of cardiovascular disease risk factors in childhood and their impact on health in adulthood.

- The Bogalusa Heart Study has contributed significantly to our understanding of the development of cardiovascular disease risk factors in childhood and their impact on health in adulthood.

- The Bogalusa Heart Study has contributed significantly to our understanding of the development of cardiovascular disease risk factors in childhood and their impact on health in adulthood.

- The Bogalusa Heart Study has contributed significantly to our understanding of the development of cardiovascular disease risk factors in childhood and their impact on health in adulthood.

- The Bogalusa Heart Study has contributed significantly to our understanding of the development of cardiovascular disease risk factors in childhood and their impact on health in adulthood.
Our Community

BROTHERS Program: Brothers Reaching Out to Help Educate on Routine Screenings
Church-based Intervention for eliminating CV Health Disparities in AA
Active Presence in Community Activities

Health Ahead / Heart Smart Health Promotion Program - Schools
Blood Drives
Virtual Clinic In-Home Procedures

Veronica Gillispie-Bell, MD, FACOG
Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review

Objectives
• Long-term risks for hypertensive disorders in pregnancy
• Louisiana Maternal Mortality Report findings
• The Louisiana Perinatal Quality Collaborative (LaPQC)

Hypertensive Disorders, 1993-2014

Our Community

Louisiana Perinatal Quality Collaborative

VERONICA GILLISPIE-BELL, MD FACOG
Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review

Questions | Collaboration

EMAIL: cfernan1@tulane.edu
VISIT: www.clersite.org
CALL: (504) 988-7323

Camilo Fernandez, MD, MSc, MBA

Questions | Collaboration

Long-term effects of hypertensive disorders in pregnancy
• Women who experience a hypertensive disorder in pregnancy have an increased risk of cardiovascular disease, stroke, peripheral artery disease, cardiovascular mortality

Long-term effects of hypertensive disorders in pregnancy
• 4 to 8 times higher rate of cardiovascular disease in women with recurrent pre-eclampsia
• 2 times the risk of cardiovascular disease
• 5 times higher rate of hypertension

Clera

Reducing Maternal Morbidity and Mortality in Louisiana: Addressing Severe Hypertension

Veronica Gillispie-Bell, MD, FACOG
Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review Obstetrics & Gynecology

Hypertensive Disorders, 1993-2014

*Data on Selected Pregnancy Complications in the United States. CDC.
KEY FINDINGS
• Maternal Mortality: a maternal death occurring within 42 days of termination of pregnancy

Between 2011-2016, maternal mortality rate increased by an average of 34% per year
• 12.4 per 100,000 live births

KEY FINDINGS
• Leading cause of death – Hypertension related (cardiomyopathy, cardiovascular conditions, preeclampsia/eclampsia) – Hemorrhage

45% were deemed to be preventable

Altering Outcomes
The assessments of preventability and chance to alter outcomes help prioritize future areas of intervention and action.

Why do health disparities exist?
• Implicit bias
  – Implicit bias is unconscious judgment and/or behaviors that affect how we interact with others
  – Impacts patient-provider interactions, treatment decisions, treatment adherence and patient health outcomes
  – https://implicit.harvard.edu/implicit/takeatest.html
• Social determinants of health
  – Racial residential segregation
  – Health care services
  – Socioeconomic status
  – Healthy behaviors

Louisiana Perinatal Quality Collaborative (LaPQC)
  – A network of perinatal care providers, public health professionals and patient and community advocates who work to improve outcomes for women, families, and newborns in Louisiana
  – Required for level 1-4 perinatal hospitals
  – All of the birthing facilities are participating

Louisiana Perinatal Quality Collaborative (LaPQC)
• What is the goal of the LaPQC?
  – Achieve a 20% reduction in severe maternal morbidity among pregnant and postpartum women who experience hemorrhage or severe hypertension/eclampsia in participating birth facilities by Mother’s Day 2020
  – Narrow the Black-white disparity in this outcome
Louisiana Perinatal Quality Collaborative (LaPQC)

- What does the LaPQC do?
  - Facilitate collaborative learning opportunities through Learning Sessions and monthly calls
  - Identify and share best practices
  - Provide teams with a data portal to allow for real-time evaluation to guide decision-making
  - Provide subject-matter experts who are brought on as Faculty
  - Coordinate a guiding Advisory Committee
  - Ensure Louisiana's work is connected to national initiatives

LaPQC Change Package

Achieve a 20% reduction in severe maternal morbidity among pregnant/postpartum women who experience hemorrhage or severe HTN in LaPQC participating facilities

Narrow the Black-White disparity in this outcome

Reliable Clinical Processes
- Assure readiness
- Improve recognition and prevention
- Understand & reduce variation in response
- Eliminate waste
- Reduce variation in reporting
- Change the work environment
- Improve work flow

Engaged Perinatal Leadership
- Manage for quality & systems learning
- Enhance patient & family relationships
- Change the work environment
- Design for partnership
- Invest in improvement

Change Goals
- Make it easy to do the right thing
- Hardwire changes into routine practice
- All improvement is change, not all change is improvement
- Change structure, process, and culture
- Build measurement into processes, and learn where there are disparities

Call to Action
- Learn from case reviews and debriefs to innovate
- Change the way physicians, midwives, nurses, patients, families communicate and work together (prenatal care, hospital discharge, ED)
- You can be a leader in the state
- Engage all providers and facility executives
  - Measure, report, and sustain positive change
  - Communicate with urgency, act with optimism

Hypertension in Pregnancy Toolkit

Alliance for Innovation on Maternal Health (AIM) a toolkit to improve maternal outcomes. There are four components:

Readiness
- Recognition
- Response
- Reporting

BTS: Model for Improvement

Model for Improvement

Our Fundamental Agreements

- Re-center the work to the who and the why
- Make care equitable by making care better and consistent
- Every woman, every time
- Change is necessary, change is important, change is personal

References

6. CMQCC Preeclampsia ToolKit: Preeclampsia Care Guidelines

Sankofa Community Development Corporation

DANIELLE GUILLORY, MD, PhD
Healthy HeartBeats Program
Quality Improvement: Focus on NQI Measures

**Approach:**
- Partnership with Louisiana Healthcare Quality Forum practice coaches
- Provided technical assistance and on-site practice coaching to 14 health clinics, including several Rural Health Clinics and one Federally Qualified Health Center from 2016-2018

**Intervention:**
- Utilized EHR to produce reports of National Quality Improvement measures for diabetes and hypertension control
- Identified opportunities and updated processes to improve overall outcomes, utilizing a Plan-Do-Study-Act approach
- Referral forms
- Patient surveys
- Policies
- Standard Operating Procedures

**Outcomes:**
- All sites were able to produce a report of NQI measures at conclusion of intervention
- Three sites tracked additional process measures.

### Quality Improvement: Focus on NQI Measures

| Activity | % Change | % Max | % Min | % National
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>50%</td>
<td>60%</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Post</td>
<td>50%</td>
<td>60%</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Intervention</td>
<td>50%</td>
<td>60%</td>
<td>40%</td>
<td>60%</td>
</tr>
</tbody>
</table>

**Participating site feedback**
- Positive impact: "The action plan was effective, and following this led to an overall improvement in our target measures."
- Sustainability: "After completion, we have continued to utilize the processes that contributed to this project."
- Competing priorities: Some clinics were unable to assign a dedicated staff member to this project.
- Health IT: "We had some persistent difficulties with utilizing our EHR. We addressed with the EHR provider and anticipate future improvements."

**Million Hearts: Hiding in Plain Sight**

- Activities to impact heart disease in the clinical setting
**Million Hearts: Hiding in Plain Sight**

**Approach:**
- Partnership with the Louisiana Public Health Institute
- Implement the Hiding in Plain Sight protocol outlined by the Million Hearts initiative
- Identify individuals with undiagnosed hypertension within a Federally Qualified Health Center

**Intervention:**
- Staff at the FQHC conducted a manual chart review to identify patients with elevated blood pressure, regardless of the presence of a diagnosis
- Reviewed over 500 charts

**Outcomes:**
- Identified 100 patients with potentially undiagnosed hypertension

**Total Identified** | **Description** | **Planned Follow-up**
--- | --- | ---
100 | Diagnosis in chart | 
15 | Diagnosis present in chart but missing from EHR | Added diagnosis to EHR
19 | Untreated/Resolved | Pt had high BP at least once, but trend did not continue in hypertensive range | No current follow-up needed
9 | Diagnosed at next visit | Pt had high BP at least once but was caught and diagnosed at subsequent visit | No current follow-up needed
10 | Medicated but undiagnosed | Likely receiving HTN medication but diagnosed for comorbidity, i.e. diabetes | Flagged for PCP to review and see if diagnosis should be added
47 | Undiagnosed/Untreated | Potential hiding in plain sight cohort | Bring in for blood pressure screening, if high BP reading, triage for a PCP review for diagnosis and treatment

**Conclusions**
- Inability to use the EHR to pull the report made this a less sustainable initiative
- FQHC made improvements to their patient visit workflow in order to ensure future patients met with a provider to receive a diagnosis
- Staff reviewed proper documentation procedures to reduce the number of missing documented diagnoses

**Almost Lunch**

**Coffee and Conversation**

**Lunch**

Resume at 12:45 pm

**Afternoon Breakouts / Facilitated Discussions**

**John Bartkus**
Principal Program Manager
Pensivia
Breakout Workgroups

Topics based on the LA planning committee priorities...

1 PROVIDER ENGAGEMENT
   - Awareness
   - Management Efforts

2 SELF-MEASURED BLOOD PRESSURE MONITORING
   - Program with Clinical Support

3 CLINICAL - COMMUNITY PARTNERSHIPS
   - for Hypertension Management

1 PROVIDER ENGAGEMENT
   - Chelsea Moreau
   - Latraiel Courtney
   - Melissa Martin
   - John Clymer

2 SELF-MEASURED BLOOD PRESSURE MONITORING
   - Danielle Galliery
   - Kathy King
   - Kelly Hanley
   - Sharon Nelson

3 CLINICAL - COMMUNITY PARTNERSHIPS
   - Colleen Arceneaux
   - Brian Burton
   - Ashley Hebert
   - Erin Leonard
   - Julia Schneider

Workgroup Objectives

- Share Activities / Resources
- Identify Alignments / Connections
- Define Next Steps / Sustainability

Wrap Up / Adjourn

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

Evaluation and Feedback Process

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

Group Report Outs

Alignment and Connections

Leverage your Partner Profiles which came from the pre-meeting questionnaire.
## Organization Type

*Indicate all that apply*

- Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
- Community Health Center, Non-FQHC
- Multi-Specialty Practice
- Primary Care Practice
- Specialty Practice
- Residency Practice
- Academic Medical Center
- Health Care System
- Department of Health

**Yes** National Non-Profit focused on Heart Disease and Stroke

---

## Provider Engagement

Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?

**Yes**

**Strategies/Approaches:** Target: BP and MAP Framework

**Successes:** Team-based approach incorporating treatment algorithms

**Challenges/Barriers:** Leadership Buy-In

**Resources to Share:** Printable patient and provider resources; Videos for both patients and providers; Free CEUs

---

## SMBP Programs

Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?

**Yes**

**Strategies/Approaches:** Empower Patients to Self-Manage

**Priority Audience:** Hypertensive Patients

**Successes:** Reduce Staff Burden and Serve as a Resource for Patients

**Challenges/Barriers:** Training Strategies to be Deployed

**Resources to Share:** SMBP Training Videos in English and Spanish

---

## Clinical-Community Partnerships

Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?

**Yes**

**Strategies/Approaches:** Food Insecurity Screening & Linkages

**Priority Audience:** Food Insecure

**Successes:** Increased Access to Healthy Food

**Challenges/Barriers:** Transportation

**Resources to Share:** Directory to Food Banks in South Louisiana

---

## Other

**Other Strategies:** Measuring Blood Pressure Accurately

**Partners:** Well-Ahead Louisiana; Feeding Louisiana; Second Harvest Food Bank
### Organization Type

<table>
<thead>
<tr>
<th>Indicate all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Community Health Center, Non-FQHC</td>
</tr>
<tr>
<td>Multi-Specialty Practice</td>
</tr>
<tr>
<td>Primary Care Practice</td>
</tr>
<tr>
<td>Specialty Practice</td>
</tr>
<tr>
<td>Residency Practice</td>
</tr>
<tr>
<td>Academic Medical Center</td>
</tr>
<tr>
<td>Health Care System</td>
</tr>
<tr>
<td>Department of Health</td>
</tr>
</tbody>
</table>

### Provider Engagement

<table>
<thead>
<tr>
<th>Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies/Approaches:</th>
</tr>
</thead>
<tbody>
<tr>
<td>High focus on quality, metrics, transparency. monthly communication both individually and as a group.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Successes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>providers more willing to address issues and engage in process when data shared frequently</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Challenges/Barriers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP provider reliance on specialists to make decisions that can be made at the PCP level.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resources to Share:</th>
</tr>
</thead>
</table>

### SMBP Programs

<table>
<thead>
<tr>
<th>Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies/Approaches:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Priority Audience:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Successes:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Challenges/Barriers:</th>
</tr>
</thead>
</table>

| Resources to Share: |

### Clinical-Community Partnerships

<table>
<thead>
<tr>
<th>Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies/Approaches:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Priority Audience:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Successes:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Challenges/Barriers:</th>
</tr>
</thead>
</table>

| Resources to Share: |

### Other

<table>
<thead>
<tr>
<th>Other Strategies:</th>
</tr>
</thead>
</table>

| Partners: |

<table>
<thead>
<tr>
<th>Organization Type</th>
<th>Indicate all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike</td>
</tr>
<tr>
<td></td>
<td>Community Health Center, Non-FQHC</td>
</tr>
<tr>
<td></td>
<td>Multi-Specialty Practice</td>
</tr>
<tr>
<td></td>
<td>Primary Care Practice</td>
</tr>
<tr>
<td></td>
<td>Specialty Practice</td>
</tr>
<tr>
<td></td>
<td>Residency Practice</td>
</tr>
<tr>
<td></td>
<td>Academic Medical Center</td>
</tr>
<tr>
<td></td>
<td>Health Care System</td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Engagement</th>
<th>Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Strategies/Approaches:</td>
<td>Our corporation has monthly provider meetings. All new endeavors are discussed and provider input is included</td>
</tr>
<tr>
<td>Successes:</td>
<td>Provider buy in is important. They’re inclusion and suggestions have resulted in success.</td>
</tr>
<tr>
<td>Challenges/Barriers:</td>
<td>Some challenges are when providers just don’t want to engage/perform the task presented or feel a certain endeavor is time consuming</td>
</tr>
<tr>
<td>Resources to Share:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SMBP Programs</th>
<th>Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Strategies/Approaches:</td>
<td>Our organization have care plans and B/P logs for our HTN patients. Care plan goals are updated at each visit and b/p logs evaluated and analyzed.</td>
</tr>
<tr>
<td>Priority Audience:</td>
<td>The patient and staff</td>
</tr>
<tr>
<td>Successes:</td>
<td>We have an increase in b/p management with patient accountability. We have found patients are more compliant when they have to bring their log for analysis.</td>
</tr>
<tr>
<td>Challenges/Barriers:</td>
<td>Non-compliance</td>
</tr>
<tr>
<td>Resources to Share:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical-Community Partnerships</th>
<th>Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Strategies/Approaches:</td>
<td></td>
</tr>
<tr>
<td>Priority Audience:</td>
<td></td>
</tr>
<tr>
<td>Successes:</td>
<td></td>
</tr>
<tr>
<td>Challenges/Barriers:</td>
<td></td>
</tr>
<tr>
<td>Resources to Share:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Strategies:</td>
<td>Patient education and educational material is given at each office visit</td>
</tr>
<tr>
<td>Partners:</td>
<td></td>
</tr>
</tbody>
</table>
### Organization Type

*Indicate all that apply*

- Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
- Community Health Center, Non-FQHC
- Multi-Specialty Practice
- Primary Care Practice
- Specialty Practice
- Residency Practice
- Academic Medical Center
- Health Care System
- Department of Health

**Yes** Rural Health Clinic

### Provider Engagement

*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*

**Strategies/Approaches:**
- Education Regarding Programs Available

**Successes:**
- Success of PT compliance

**Challenges/Barriers:**
- Transportation

**Resources to Share:**
- Rapides Foundation

### SMBP Programs

*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*

**Strategies/Approaches:**
- EDUCATION ABOUT SELF REPORTING WHEN OUT OF RANGE
  - UNCONTROLLED BP

**Successes:**
- FINANCIAL

**Challenges/Barriers:**
- FINANCIAL

**Resources to Share:**

### Clinical-Community Partnerships

*Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*

**No**

**Strategies/Approaches:**

**Priority Audience:**

**Successes:**

**Challenges/Barriers:**

**Resources to Share:**

### Other

**Other Strategies:**
- PROGRAM CALLED HEALTHY LIFESTYLE

**Partners:**
- RAPIDES FOUNDATION
### Organization Type

<table>
<thead>
<tr>
<th>Indicate all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike</td>
</tr>
<tr>
<td>Community Health Center, Non-FQHC</td>
</tr>
<tr>
<td>Multi-Specialty Practice</td>
</tr>
<tr>
<td>Primary Care Practice</td>
</tr>
<tr>
<td>Specialty Practice</td>
</tr>
<tr>
<td>Residency Practice</td>
</tr>
<tr>
<td>Academic Medical Center</td>
</tr>
<tr>
<td>Health Care System</td>
</tr>
</tbody>
</table>

| Yes | Department of Health |

### Provider Engagement

**Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?**

<table>
<thead>
<tr>
<th>Strategies/Approaches:</th>
<th>Direct email communication; arranging Zoom meetings; plan to arrange regional dinner meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successes:</td>
<td>Some slightly improved provider engagement</td>
</tr>
<tr>
<td>Challenges/Barriers:</td>
<td>providers making time during clinical time to attend learning sessions</td>
</tr>
</tbody>
</table>

### SMBP Programs

**Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?**

<table>
<thead>
<tr>
<th>Strategies/Approaches:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Audience:</td>
</tr>
<tr>
<td>Successes:</td>
</tr>
<tr>
<td>Challenges/Barriers:</td>
</tr>
<tr>
<td>Resources to Share:</td>
</tr>
</tbody>
</table>

**No**

### Clinical-Community Partnerships

**Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?**

<table>
<thead>
<tr>
<th>Strategies/Approaches:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Audience:</td>
</tr>
<tr>
<td>Successes:</td>
</tr>
<tr>
<td>Challenges/Barriers:</td>
</tr>
<tr>
<td>Resources to Share:</td>
</tr>
</tbody>
</table>

**No**

### Other

<table>
<thead>
<tr>
<th>Other Strategies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners:</td>
</tr>
</tbody>
</table>
### Organization Type

*Indicate all that apply*

- Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
- Community Health Center, Non-FQHC
- Multi-Specialty Practice
- Primary Care Practice
- Specialty Practice
- Residency Practice
- Academic Medical Center
- Health Care System
- Department of Health

Yes Medicaid Managed Care Organization

### Provider Engagement

<table>
<thead>
<tr>
<th>Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

**Strategies/Approaches:**

- Provider education of related NCQA HEDIS measures/value based payments focused on Quality measures/HEDIS
- Health Fairs/Free Clinics

**Successes:**

**Challenges/Barriers:**

**Resources to Share:**

### SMBP Programs

<table>
<thead>
<tr>
<th>Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

**Strategies/Approaches:**

**Priority Audience:**

**Successes:**

**Challenges/Barriers:**

**Resources to Share:**

### Clinical-Community Partnerships

<table>
<thead>
<tr>
<th>Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

**Strategies/Approaches:**

- MetroMorphosis/Urban Congress Hair & Health sponsorship
- African-American men

**Priority Audience:**

**Successes:**

**Challenges/Barriers:**

**Resources to Share:**

### Other

**Other Strategies:**

`LPCA, AHA, MetroMorphosis`
### Organization Type

<table>
<thead>
<tr>
<th>Indicate all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike</td>
</tr>
<tr>
<td>Community Health Center, Non-FQHC</td>
</tr>
<tr>
<td>Multi-Specialty Practice</td>
</tr>
<tr>
<td>Primary Care Practice</td>
</tr>
<tr>
<td>Specialty Practice</td>
</tr>
<tr>
<td>Residency Practice</td>
</tr>
<tr>
<td>Academic Medical Center</td>
</tr>
<tr>
<td>Health Care System</td>
</tr>
<tr>
<td>Department of Health</td>
</tr>
</tbody>
</table>

Yes Louisiana Primary Care Association

### Provider Engagement

<table>
<thead>
<tr>
<th>Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies/Approaches:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Successes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Challenges/Barriers:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resources to Share:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### SMBP Programs

<table>
<thead>
<tr>
<th>Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies/Approaches:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently 1-2 health centers are implementing the Remote Patient Monitoring Program through Certintell which involves remote BP monitoring; We are currently introducing this to other health centers in Louisiana</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority Audience:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally Qualified Health Centers and their respective hypertensive patient population</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Successes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>This program is fairly new so we don’t have any data right now to show.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Challenges/Barriers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>This program is fairly new so we don’t have information on this right now. We will send out a survey once we get enough health centers on the Certintell platform to collect this information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resources to Share:</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are currently in partnership with Certintell Telehealth. We also partner with the Louisiana Department of Health for the 1815 grant that we manage which covers hypertension and diabetes in the FQHC patient population.</td>
</tr>
</tbody>
</table>

### Clinical-Community Partnerships

<table>
<thead>
<tr>
<th>Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies/Approaches:</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have partnered with Certintell Telehealth for chronic care management of hypertensive and diabetic patients as well as Remote Patient Monitoring for blood pressure, diabetes, weight management, etc.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority Audience:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Qualified Health Centers patient population for hypertension.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Successes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>This partnership occurred within the last month so we don’t have any information on success stories yet.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Challenges/Barriers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>This partnership occurred within the last month so we don’t have any information on challenges/barriers yet.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resources to Share:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certintell staff, FQHC staff (LCSW, Medical Assistants, HIT staff, Quality staff</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Other Strategies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Director of Quality normally provides trainings for providers on evidence-based practices for chronic disease management.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Partners:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louisiana Department of Health, MCO’s, etc.</td>
</tr>
</tbody>
</table>

---

Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners  
Working Together in Louisiana - September 25, 2019  
Page 7 of 16
**Organization Type**

<table>
<thead>
<tr>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike</td>
</tr>
<tr>
<td>Community Health Center, Non-FQHC</td>
</tr>
<tr>
<td>Multi-Specialty Practice</td>
</tr>
<tr>
<td>Primary Care Practice</td>
</tr>
<tr>
<td>Specialty Practice</td>
</tr>
<tr>
<td>Residency Practice</td>
</tr>
<tr>
<td>Academic Medical Center</td>
</tr>
<tr>
<td>Health Care System</td>
</tr>
<tr>
<td>Department of Health</td>
</tr>
</tbody>
</table>

**Provider Engagement**

- **No**
  - Does your Organization implement strategies to increase Provider Engagement (individual and health system level)?
  - Strategies/Approaches:
  - Successes:
  - Challenges/Barriers:
  - Resources to Share:

**SMBP Programs**

- **No**
  - Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?
  - Strategies/Approaches:
  - Priority Audience:
  - Successes:
  - Challenges/Barriers:
  - Resources to Share:

**Clinical-Community Partnerships**

- **No**
  - Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?
  - Strategies/Approaches:
  - Priority Audience:
  - Successes:
  - Challenges/Barriers:
  - Resources to Share:

**Other**

- Other Strategies: Life style changes, diet, exercise and compliance with medications
- Partners:
## Organization Type

**Indicate all that apply**

- Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
- Community Health Center, Non-FQHC
- Multi-Specialty Practice
- Primary Care Practice
- Specialty Practice
- Residency Practice
- Academic Medical Center
- Health Care System
- Department of Health

## Provider Engagement

No  Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?

**Strategies/Approaches:**

**Successes:**

**Challenges/Barriers:**

**Resources to Share:**

## SMBP Programs

Yes  Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?

**Strategies/Approaches:**

- participate in Target: BP
- primary care and cardiology patients
- overall bp reduction
- organization-wide education

**Priority Audience:**

**Successes:**

**Challenges/Barriers:**

**Resources to Share:**

## Clinical-Community Partnerships

No  Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?

**Strategies/Approaches:**

**Priority Audience:**

**Successes:**

**Challenges/Barriers:**

**Resources to Share:**

## Other

**Other Strategies:**

**Partners:**
### Organization Type

<table>
<thead>
<tr>
<th>Indicate all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike</td>
</tr>
<tr>
<td>Community Health Center, Non-FQHC</td>
</tr>
<tr>
<td>Multi-Specialty Practice</td>
</tr>
<tr>
<td>Primary Care Practice</td>
</tr>
<tr>
<td>Specialty Practice</td>
</tr>
<tr>
<td>Residency Practice</td>
</tr>
<tr>
<td>Academic Medical Center</td>
</tr>
<tr>
<td>Health Care System</td>
</tr>
<tr>
<td>Department of Health</td>
</tr>
</tbody>
</table>

**Yes** Medicare Quality Improvement Organization

### Provider Engagement

**Yes** Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?

**Strategies/Approaches:** Blood pressure and medication teaching during rural and underserved Diabetic Education

**Successes:** Training of peer educators to sustain the program after the CMS contract ends.

**Challenges/Barriers:** Transportation to class, office staff understanding protocols

**Resources to Share:** UIC, DEEP [https://mwlatino.uic.edu/deep-program-2/](https://mwlatino.uic.edu/deep-program-2/)

### SMBP Programs

**Yes** Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?

**Strategies/Approaches:**

- Priority Audience: rural and underserved medicare beneficiaries

**Successes:**

**Challenges/Barriers:**

**Resources to Share:**

### Clinical-Community Partnerships

**No** Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?

**Strategies/Approaches:**

- Priority Audience:

- Successes:

- Challenges/Barriers:

- Resources to Share:

### Other

**Other Strategies:**

**Partners:**

---
## Organization Type

<table>
<thead>
<tr>
<th>Indicate all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike</td>
</tr>
<tr>
<td>Community Health Center, Non-FQHC</td>
</tr>
<tr>
<td>Multi-Specialty Practice</td>
</tr>
<tr>
<td>Primary Care Practice</td>
</tr>
<tr>
<td>Specialty Practice</td>
</tr>
<tr>
<td>Residency Practice</td>
</tr>
<tr>
<td>Academic Medical Center</td>
</tr>
<tr>
<td>Health Care System</td>
</tr>
<tr>
<td>Department of Health</td>
</tr>
</tbody>
</table>

Yes  Louisiana Public Health Institute

## Provider Engagement

Yes  Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?

**Strategies/Approaches:**
- Promotion of the Quitline, Fax Referrals to the Quitline, Promote quit resources

**Successes:**
- Increased referrals to the quitline; Promotion of counseling services for smokers

**Challenges/Barriers:**
- Ease of completing the fax referral

**Resources to Share:**
- www.quitwithusla.org website; Quit With Us social media sites; brochures and marketing materials

## SMBP Programs

No  Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?

**Strategies/Approaches:**

**Priority Audience:**

**Successes:**

**Challenges/Barriers:**

**Resources to Share:**

## Clinical-Community Partnerships

No  Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?

**Strategies/Approaches:**

**Priority Audience:**

**Successes:**

**Challenges/Barriers:**

**Resources to Share:**

## Other

**Other Strategies:**
- none

**Partners:**
- none
### Organization Type

*Indicate all that apply*
- Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
- Community Health Center, Non-FQHC
- Multi-Specialty Practice
- Primary Care Practice
- Specialty Practice
- Residency Practice
- Academic Medical Center
- Health Care System
- Department of Health

- **Yes** Tulane University, Bogalusa Heart Study

### Provider Engagement

<table>
<thead>
<tr>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?</td>
</tr>
<tr>
<td>Strategies/Approaches:</td>
</tr>
<tr>
<td>Successes:</td>
</tr>
<tr>
<td>Challenges/Barriers:</td>
</tr>
<tr>
<td>Resources to Share:</td>
</tr>
</tbody>
</table>

### SMBP Programs

<table>
<thead>
<tr>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?</td>
</tr>
<tr>
<td>Strategies/Approaches:</td>
</tr>
<tr>
<td>Priority Audience:</td>
</tr>
<tr>
<td>Successes:</td>
</tr>
<tr>
<td>Challenges/Barriers:</td>
</tr>
<tr>
<td>Resources to Share:</td>
</tr>
</tbody>
</table>

### Clinical-Community Partnerships

<table>
<thead>
<tr>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?</td>
</tr>
<tr>
<td>Strategies/Approaches: The partnership facilitates training local barbers to take blood pressure.</td>
</tr>
<tr>
<td>Priority Audience: Our priority audience is hypertensive men with a focus on African Americans.</td>
</tr>
<tr>
<td>Successes: Partnership in the community-clinical area is a success in itself. While the program is still in its infancy, a variety of community and clinical stakeholders participate.</td>
</tr>
<tr>
<td>Challenges/Barriers: One challenge is that the clinical area is new to some community stakeholders.</td>
</tr>
<tr>
<td>Resources to Share: N/A</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Other Strategies: All BHS participants have blood pressure measured and are referred to care if elevated.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners: Well Ahead Louisiana, Our Lady of the Angels</td>
</tr>
</tbody>
</table>
### Organization Type

<table>
<thead>
<tr>
<th>Indicate all that apply</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike</td>
<td></td>
</tr>
<tr>
<td>Community Health Center, Non-FQHC</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Multi-Specialty Practice</td>
</tr>
<tr>
<td>Primary Care Practice</td>
<td></td>
</tr>
<tr>
<td>Specialty Practice</td>
<td></td>
</tr>
<tr>
<td>Residency Practice</td>
<td></td>
</tr>
<tr>
<td>Academic Medical Center</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Health Care System</td>
</tr>
<tr>
<td>Department of Health</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>General Hospital</td>
</tr>
</tbody>
</table>

### Provider Engagement

<table>
<thead>
<tr>
<th>Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies/Approaches</th>
<th>Press Ganey and Leader Rounding on staff and other departments; Quarterly Physician Rounding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successes</td>
<td>Issues are discussed in a small multidisciplinary approach and search for solutions; Increased Press Ganey Physician Engagement Scores</td>
</tr>
<tr>
<td>Challenges/Barriers</td>
<td>Financial constraints; Engaging physicians in departmental improvements</td>
</tr>
<tr>
<td>Resources to Share</td>
<td></td>
</tr>
</tbody>
</table>

### SMBP Programs

<table>
<thead>
<tr>
<th>Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies/Approaches</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Audience</td>
<td></td>
</tr>
<tr>
<td>Successes</td>
<td></td>
</tr>
<tr>
<td>Challenges/Barriers</td>
<td></td>
</tr>
<tr>
<td>Resources to Share</td>
<td></td>
</tr>
</tbody>
</table>

### Clinical-Community Partnerships

<table>
<thead>
<tr>
<th>Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies/Approaches</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Audience</td>
<td></td>
</tr>
<tr>
<td>Successes</td>
<td></td>
</tr>
<tr>
<td>Challenges/Barriers</td>
<td></td>
</tr>
<tr>
<td>Resources to Share</td>
<td></td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Other Strategies</th>
<th>Patient education sessions held by physicians and health fairs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners</td>
<td>Local physicians</td>
</tr>
</tbody>
</table>
**Organization Type**  
*Indicate all that apply*
- Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
- Community Health Center, Non-FQHC
- Multi-Specialty Practice
- Primary Care Practice
- Specialty Practice
- Residency Practice

*Yes*  
- Academic Medical Center
- Health Care System
- Department of Health
- Community Based Organization / Public Health Foundation

**Provider Engagement**

*Yes*  
*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*

**Strategies/Approaches:** We provide healthcare provider education, CEUs/CMEs for continuing education, capacity building, clinical quality improvement coaching; Well-Ahead initiatives

**Successes:** all strategies are used to increase provider capacity

**Challenges/Barriers:** the willingness for healthcare providers to take on additional tasks within the time allotted to a patient.

**Resources to Share:** Physician Network, CMEs/CEUs to provide to healthcare providers, full time Practice Coach to lead healthcare facilities in clinical quality improvement

**SMBP Programs**

*No*  
*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*

**Strategies/Approaches:**

**Priority Audience:**

**Successes:**

**Challenges/Barriers:**

**Resources to Share:**

**Clinical-Community Partnerships**

*Yes*  
*Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*

**Strategies/Approaches:** Partnership with the Louisiana Health Department to work with healthcare centers to identify opportunities for clinical quality improvement measures for hypertension

**Priority Audience:** rural health centers

**Successes:** Very new project. We are beginning this process

**Challenges/Barriers:** This is a very new project

**Resources to Share:** N/A at this time

**Other**

**Other Strategies:**

**Partners:**
### Organization Type

<table>
<thead>
<tr>
<th>Indicate all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike</td>
</tr>
<tr>
<td>Community Health Center, Non-FQHC</td>
</tr>
<tr>
<td>Multi-Specialty Practice</td>
</tr>
<tr>
<td>Primary Care Practice</td>
</tr>
<tr>
<td>Specialty Practice</td>
</tr>
<tr>
<td>Residency Practice</td>
</tr>
<tr>
<td>Academic Medical Center</td>
</tr>
<tr>
<td>Health Care System</td>
</tr>
</tbody>
</table>

- Yes Department of Health

### Provider Engagement

**Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?**

- Yes

**Strategies/Approaches:**
- Well-Ahead Provider Education Network; Provider trainings with continuing education credits offered, webinars, toolkits; Population Health Cohort

**Successes:**
- Successful reach in providers involved in WALPEN (Provider Education Network), reach of provider trainings and webinars.

**Challenges/Barriers:**
- Keeping up the momentom. Finding time to implement changes in routine to their daily practice.

**Resources to Share:**
- 1. https://www.walpen.org/ - offers technical assistance regarding workforce and health systems development and provides opportunities for provider education, population health management and collaboration. WAL-PEN accomplishes this through continuing education and training opportunities, providing updated lists of prevention programs to refer patients to learn about and manage their condition, offering tobacco cessation training.
- 2. is an exclusive collaborative quality improvement opportunity which support the implementation of strategies aimed at improving population health within a primary care setting, with specific focus on chronic disease related outcomes. Louisiana providers and their facilities have the opportunity to have hands-on assistance in implementing evidence-based practices that can improve their quality of care and their patient’s health outcomes.
- Available tobacco cessation resources.

### SMBP Programs

**Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?**

- Yes

**Strategies/Approaches:**
- Creation of community clinical linkages utilizing community-based organization within underserved populations to identify individuals who are at risk.;
- Provide technical assistance to organizations interested in starting a Self-Measured Blood Pressure Monitoring Program; Community and clinical based practices;

**Priority Audience:**
- African American males with undiagnosed high blood pressure; Barbershops, Faith-Based Organizations, Councils on Aging, senior centers and non-profits; Target populations; African American, Low SES, Chronic Disease; Rural Health Clinics

**Successes:**
- Cutt’n the Pressure in Bogalusa, LA in partnership with Our Lady of Angels Hospital trained 3 barbers to implement SMBP in their shops.

**Challenges/Barriers:**
- Legalities involved in collecting community member PHI for clinical use while ensuring that completion of consent forms is as minimal of a barrier to participation as possible.

**Resources to Share:**
- Have created a toolkit to provide a template on how to create a successful SMBP Program.

### Clinical-Community Partnerships

**Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?**

- Yes

**Strategies/Approaches:**
- Community Resource Coordinators and WISEWOMAN grant; Partnering with specific clinics to provide resources and interventions to those who have barriers accessing treatments.
- We utilize a community resource coordinator to help assist with locating resources within the region.

**Priority Audience:**
- Low SES, Un or underinsured, chronic disease

**Successes:**
- Resources are limited in rural areas.
## Resources to Share
Community Resources Coordinators work in the community to identify NDPP, DSMES and SMBP programs and link those community resources to healthcare providers.  2. The WISEWOMAN grant provides health screenings to eligible women to assess their risk for heart disease. Participating women are provided free membership for lifestyle programs, or health coaching to improve their health outcomes.

### Other Strategies

<table>
<thead>
<tr>
<th>Partners</th>
<th>American Heart Association</th>
</tr>
</thead>
</table>

---

**Other**

---

**Respondent(s):** Kaitlyn King; Erin Leonard; Taylor Reine; Audrey Shields; Rebecca Wilkes