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
Welcome and Opening Remarks

**John Clymer**
Executive Director
National Forum for Heart Disease and Stroke Prevention
Co-chair, Million Hearts® Collaboration

**Julie Harvill**
Operations Manager
Million Hearts® Collaboration
American Heart Association
Overview of the Day

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

• Welcome & Overview of the Day
• Introductions
• Million Hearts® 2022 Update
• Louisiana Department of Health Hypertension Initiatives
• Quality Insights, Quality Innovation Network
• American Heart Association Hypertension Initiatives

• Louisiana Partner Hypertension Initiatives
  • Partnering with providers to implement sustainable systems changes
  • Bogalusa Heart Study and Hypertension
  • Louisiana Perinatal Quality Collaborative
  • Sankofa Community Development Corporation
  • Rural Health Center Hypertension Programs

• Lunch @ 12:00 noon

• Facilitated Discussions / Breakouts (x3)

• Group Report Outs and Next Steps
• Evaluation and Feedback Process
• Wrap up / Adjourn
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)*
Outcome?
Alignment

Coordination of Purpose, Focus and Energy
Higher Impact on the target
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
Leverage your Partner Profiles which came from the pre-meeting questionnaire.
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
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention
Preventing 1 Million Heart Attacks and Strokes by 2022

Tiffany Fell
Deputy Associate Director, PERC
Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention
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
Heart Disease and Stroke in the U.S.

• More than **1.5 million** people in the U.S. suffer from heart attacks and strokes per year\(^1\)

• More than **800,000** deaths per year in the U.S. from cardiovascular disease (CVD)\(^1\)

• CVD costs the U.S. **hundreds of billions** of dollars per year\(^1\)

• CVD is the greatest contributor to racial disparities in life expectancy\(^2\)

References
Parish-level death rates

Heart disease death rates are increasing in over two-thirds of parishes.
Million Hearts-preventable event rates among adults aged ≥18 years by state, 2016

What this means for Louisiana

• 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
### Keeping People Healthy

<table>
<thead>
<tr>
<th>Priority</th>
</tr>
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<tbody>
<tr>
<td>Reduce Sodium Intake</td>
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<tr>
<td>Decrease Tobacco Use</td>
</tr>
<tr>
<td>Increase Physical Activity</td>
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</tbody>
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### Optimizing Care

<table>
<thead>
<tr>
<th>Priority</th>
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<tbody>
<tr>
<td>Improve ABCS*</td>
</tr>
<tr>
<td>Increase Use of Cardiac Rehab</td>
</tr>
<tr>
<td>Engage Patients in Heart-Healthy Behaviors</td>
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### Improving Outcomes for Priority Populations

<table>
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<tr>
<th>Priority</th>
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<tbody>
<tr>
<td>Blacks/African Americans with hypertension</td>
</tr>
<tr>
<td>35- to 64-year-olds</td>
</tr>
<tr>
<td>People who have had a heart attack or stroke</td>
</tr>
<tr>
<td>People with mental and/or substance use disorders</td>
</tr>
</tbody>
</table>

*Aspirin use when appropriate, Blood pressure control, Cholesterol management, Smoking cessation*
# Keeping People Healthy

<table>
<thead>
<tr>
<th>Goals</th>
<th>Effective Public Health Strategies</th>
</tr>
</thead>
</table>
| **Reduce Sodium Intake**    | • Enhance consumers’ options for lower sodium foods  
| Target: 20%                  | • Institute healthy food procurement and nutrition policies  
|                               |                                                                                                                                                                                  |
| **Decrease Tobacco Use**      | • Enact smoke-free space policies that include e-cigarettes  
| Target: 20%                   | • Use pricing approaches  
|                               | • Conduct mass media campaigns  
| **Increase Physical Activity**| • Create or enhance access to places for physical activity  
| Target: 20%                   | • Design communities and streets that support physical activity  
| (Reduction of inactivity)     | • Develop and promote peer support programs  

![Million Hearts](image)
## Optimizing Care

### Goals

<table>
<thead>
<tr>
<th>Goals</th>
<th>Effective Health Care Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improve ABCS</strong></td>
<td><em>High Performers Excel in the Use of...</em></td>
</tr>
<tr>
<td>Targets: 80%</td>
<td>• <strong>Teams</strong>—including pharmacists, nurses, community health workers, and cardiac rehab professionals</td>
</tr>
<tr>
<td></td>
<td>• <strong>Technology</strong>—decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care</td>
</tr>
<tr>
<td></td>
<td>• <strong>Processes</strong>—treatment protocols; daily huddles; ABCS scorecards; proactive outreach; finding patients with undiagnosed high BP, high cholesterol, or tobacco use</td>
</tr>
<tr>
<td><strong>Increase Use of Cardiac Rehab</strong></td>
<td>• <strong>Patient and Family Supports</strong>—training in home blood pressure monitoring; problem-solving in medication adherence; counseling on nutrition, physical activity, tobacco use, risks of particulate matter; referral to community-based physical activity programs and cardiac rehab</td>
</tr>
<tr>
<td>Target: 70%</td>
<td></td>
</tr>
<tr>
<td><strong>Engage Patients in Heart-Healthy Behaviors</strong></td>
<td></td>
</tr>
<tr>
<td>Targets: TBD</td>
<td></td>
</tr>
</tbody>
</table>

*Aspirin use when appropriate, Blood pressure control, Cholesterol management, Smoking cessation*
## Improving Outcomes for Priority Populations

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention Needs</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blacks/African Americans with hypertension</td>
<td>• Improving hypertension control</td>
<td>• Targeted protocols</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medication adherence strategies</td>
</tr>
<tr>
<td>35- to 64-year-olds</td>
<td>• Improving HTN control and statin use</td>
<td>• Targeted protocols</td>
</tr>
<tr>
<td></td>
<td>• Decreasing physical inactivity</td>
<td>• Community-based program enrollment</td>
</tr>
<tr>
<td>People who have had a heart attack or stroke</td>
<td>• Increasing cardiac rehab referral and participation</td>
<td>• Automated referrals, hospital CR liaisons, referrals to convenient locations</td>
</tr>
<tr>
<td></td>
<td>• Avoiding exposure to particulate matter</td>
<td>• Air Quality Index tools</td>
</tr>
<tr>
<td>People with mental and/or substance use disorders</td>
<td>• Reducing tobacco use</td>
<td>• Integrating tobacco cessation into behavioral health treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tobacco-free mental health and substance use treatment campuses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tailored quitline protocols</td>
</tr>
</tbody>
</table>
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 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**

Million Hearts® 2022 Website: [https://millionhearts.hhs.gov/](https://millionhearts.hhs.gov/)
Tobacco Cessation Change Package (TCCP)

Access the Change Package at:
MODULE 1: OVERVIEW

MODULE 2: SETTING GOALS

MODULE 3: PARTNERSHIPS

MODULE 4: COMMUNICATION

MODULE 5: EVALUATION & MONITORING
Hypertension Control Change Package

Recognize hospitals working systematically to improve the cv health of population/communities 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
Louisiana Department of Health Hypertension Initiatives

MELISSA R MARTIN, RDN, LDN
Well-Ahead Louisiana Director
Connecting Louisiana Communities to a Healthier Future,
a focus on Heart Disease Prevention and Management

Louisiana’s Health Initiative
Connecting Louisiana Residents to a Heathier Future

- State Office of Rural Health
- Medicare Rural Hospital Flex
- Small Hospital Improvement Program
- State Loan Repayment
- Rural Provider Support Programs
- 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
- Oral Health Promotion
- Tobacco Cessation and Prevention
- WellSpot Designation
- Healthy Community Design
Louisiana Data
Prevalence of High Blood Pressure by Parish amongst Louisiana Adults 18 years and older

Source: BRFSS 2015, 2017
Prevalence of high blood pressure among adults (18yrs and above)

BLACK NON HISPANIC: 42.3%
WHITE NON HISPANIC: 38%
Prevalence of high blood pressure among adults (18yrs and above)

- 65+ YRS: 68.2%
- 55-64 YRS: 55.4%
- 45-54 YRS: 47.2%
- 35-44 YRS: 29.3%
- 24-34 YRS: 17.2%
- 18-24 YRS: 0%
% Population ever told they have high blood pressure

- Female: 37.8%
- Male: 40.4%
% Population ever told they have high blood pressure

- Less than 15,000: 42.8%
- 15,000 - 24,999: 41.4%
- 25,000 - 34,999: 43.7%
- 35,000 - 49,999: 40.3%
- 50,000 or more: 34.3%
% Population ever told they have high blood pressure

- SOME COLLEGE: 36.1%
- HS GRAD/GED: 39.9%
- LESS THAN HS GRAD: 46.8%
% Population ever told they have high blood pressure

- MALE: 40.4
- FEMALE: 37.8
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.
Community Resource Development and Healthy Community Coaching

Self-Monitoring Blood Pressure Programs with Clinical Support

WellSpot Designation

Barbershop Project

1.800.QUIT.NOW QuitWithUsLa.Org
American Heart Association Partnership

Medication Adherence and Therapy Management

Population Health Cohort

Practice Coaches
Stay Connected
Subscribe to our WALPEN email list

Provider Education Network

You Are Invited!

Pharmacist-Provided Medication Therapy Management: A Patient’s Ally Against Chronic Disease

April 26th: 12:00pm - 1:00pm

The webinar will provide an overview of the application of Medication Therapy Management in managing a patient with chronic disease, such as hypertension or diabetes.

In this webinar, you will:
- Learn about Medication Therapy Management (MTM) and its components.
- Learn about opportunities to sustain your MTM services.
- Learn about strategies to promote your MTM services.

Click Here to Register for the Webinar.

Well-Ahead

Happy National Rural Health Day!

Well-Ahead Louisiana is proud to recognize three recipients of the National Organization of State Offices of Rural Health’s prestigious Community Star Award. Thanks for helping us move Louisiana’s health forward!

The Bogalusa Mayor’s Wellness Council was awarded for bringing together a diverse group of partners to implement Bogalusa Strong. In less than a year, Bogalusa Strong was able to launch a dairy product education campaign, host a healthy lunchroom workshop for Bogalusa school cafeteria staff, establish a bi-annual Mayor’s walk, and more.

Provider Education Network

Our Brief Tobacco Intervention Provider Training is now available online!

21.8% of Louisiana adults smoke. The majority of those who smoke are interested in quitting, but rarely receive quit assistance.

Tobacco quit rates increase when healthcare providers consistently identify and treat tobacco use. Cessation advice should be offered to every patient.

As a healthcare provider, you have a great opportunity to make tobacco use screening and cessation service referral a standard of care among your healthcare team.

Over 130 providers have participated in our Brief Tobacco Intervention Training! Don’t miss out on the training you will:

Click Here to Learn More.
Follow Us On Social Media

Well-Ahead Louisiana
Published by Sprout Social (?1) · April 17th ·
Want to make a difference this Spring Break? Then join us April 23rd for a free Building Your Diabetes Education Program! Wednesday, April 17th, is the last day to register. But don’t worry you can do it right now by clicking this link: https://www.myadenetwork.org/p/c/3d65f1fd7174

Well-Ahead Louisiana
Published by Hillary Stepson-Sutton (?1) · April 18 at 10:00am ·
The trick to staying healthy with high blood pressure is monitoring your salt intake. When grocery shopping, choose low-sodium or no salt added options.

Well-Ahead Louisiana
Published by Hillary Stepson-Sutton (?1) · April 18 at 10:00am ·
@WellAheadLA Apologies for the delay in sharing the resources. We are currently working on creating a comprehensive guide for our patients. Please stay tuned for updates.

Well-Ahead Louisiana
402 followers
In less than three minutes, you can complete our brief Tobacco Intervention Provider Training course online. Learn more: http://bit.ly/2eYfST

#HealthyHeart #BeALeader

Follow Us on:

- Facebook
- Twitter
- Instagram
- LinkedIn
Partnering With Quality Insights
Quality Innovation Network

Debra Rushing, RN, MBA
Medicare Projects Director
The QIN-QIO Program’s Approach to Clinical Quality

Aims

Foundational Principles
• Enable innovation
• Foster learning organizations
• Eliminate disparities
• Strengthen infrastructure and data systems

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
Four Key Roles of QIN-QIOs

• Facilitate Learning and Action Networks (LANs)
  – Creating an “all teach, all learn” environment

• Teach and advise as technical experts
  – Teach so learning is never lost

• 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 clinician, provider and patient/family behavior change
CMS 2014-2019 Medicare Quality Improvement Projects

- Cardiovascular Health
- Nursing Home Quality
- Quality Reporting and Payment Programs
- Readmissions
- Adult Immunizations
- Palliative Care and Hospice Referrals for Heart Failure Patients
- Quality Improvement in LTACHs

- Transforming Clinical Practice
- Antibiotic Stewardship
- Preventing Adverse Drug Events
- Everyone with Diabetes Counts
- Opioids
- Annual Wellness Visit
Hypertension focus

• 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
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 >/90mme daily
   – 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
CMS Medicare Quality Improvement Projects on the Horizon

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 ADE 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
Programs and Resources that Align with Million Hearts

American Heart Association

Coretta LaGarde
Vice President, Health Strategies
Louisiana

Ashley Hebert
Director, Government Relations
Louisiana
Who we are

The American Heart Association/ American Stroke Association is not just a charity. We are crusaders, innovators, scientists and partners.

Our Mission

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

National – Dallas HQ
- Education & awareness
- Research management
- Quality & science
- Advocacy agenda
- Strategic partnerships & alliances

5 regions
- Activate advocacy
- State and affiliate education
- Quality improvement
- Regional projects

Local
- Grassroots advocacy
- Fundraising & education
- Building partnerships
- Recruiting volunteers
- Community health
Trends in health improvements

• Part of the 2020 impact goal is to improve health by 20% - and we’re currently at 3.82%.

• In adults, we are seeing improvements in smoking rates, healthy diet, physical activity, blood pressure, cholesterol and blood pressure.

• In kids, we see improvements in smoking rates, healthy diet, blood pressure and cholesterol.

• Our work in these areas is being offset by issues such as BMI and blood glucose.

Building a culture of health in the community
Improving Health

Check. Change. Control.
& Target: BP
Nearly 86 million Americans have high blood pressure.
500,000 + People have participated in Check. Change. Control. program to lower their blood pressure.

Check. Change. Control.
Cholesterol
40% of Americans have high cholesterol.
Our goal is to move 9 million Americans to healthier cholesterol levels by 2020.

Heart-Check Mark
More than 900 products carry the Heart-Check mark.
We’re working alongside the American Diabetes Association and others to combat the growing threats from diabetes and cardiovascular diseases.

30 million American adults 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
Get with the Guidelines & Mission: Lifeline Quality Awards

Key to the Awards

**Gold Achievement 🟢 🟢 🟢 🟢**
These hospitals are recognized for two or more consecutive calendar years of 85% or higher adherence on all achievement measures applicable to each program.

**Gold Plus Achievement 🟢 🟢 🟢 🟢**
These hospitals are recognized for two or more consecutive calendar years of 85% or higher adherence on all achievement measures applicable and 75% or higher adherence with additional select quality measures in heart failure, stroke and/or resuscitation.

**Silver Achievement 🟢 🟢 🟢 🟢**
These hospitals are recognized for one calendar year of 85% or higher adherence on all achievement measures applicable to each program.

**Silver Plus Achievement 🟢 🟢 🟢 🟢**
These hospitals are recognized for one calendar year of 85% or higher adherence on all achievement measures applicable and 75% or higher adherence with additional select quality measures in heart failure, stroke and/or resuscitation.

*These hospitals received Get With The Guidelines-Resuscitation awards from the American Heart Association for two or more patient populations.*
# You’re the Cure – Advocacy

## Through our advocacy efforts:

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.8 million</td>
<td>babies are screened for congenital heart defects.</td>
</tr>
<tr>
<td>210 million</td>
<td>Americans live in smoke-free communities.</td>
</tr>
<tr>
<td>2.5 million</td>
<td>students are trained in CPR every year.</td>
</tr>
</tbody>
</table>

## Local Priorities

- Complete Streets
- Healthy Restaurant
- Kids’ Meals
- Smoke-Free
Spotlight on Louisiana
Advocacy – Policy Priorities in Louisiana

Healthy Eating / Active Living
Support efforts to increase active living and healthy eating through policy

Tobacco Free
Support efforts to decrease tobacco use in Louisiana
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 may 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.

The American Heart Association will be leading a policy effort to make milk or water the default beverage in all kids’ meals in Louisiana.
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!
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
• 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
Discussion

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

2. On which topics would you like additional information?

3. Other questions?
Contact Information

Coretta LaGarde
Coretta.Lagarde@heart.org

Ashley Hebert
Ashley.Hebert@heart.org
Break

Resume at 10:45 am
Louisiana Partner
Hypertension Initiatives
Partnering with Providers to Implement Sustainable Systems Changes

Kenny J Cole, MD, MHCDS
System VP, Clinical Improvement
Ochsner Health System
Life in Louisiana
Louisiana’s Cardiovascular Crisis

Heart Disease Death Rates, 2008-2010
Adults, Ages 35+, by County

Rates are spatially smoothed to enhance the stability of rates in counties with small populations.

Data Source:
National Vital Statistics System
National Center for Health Statistics
Measure Up
Pressure Down

- **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** to actively manage their health.
80% of Patients at Goal Blood Pressure

Processes to Achieve Goal

Direct Care Staff trained in accurate BP measurement
Hypertension Guideline used and adherence monitored
BP addressed for every hypertension patient, every primary care visit
All patients not at goal and with new Rx seen within 30 days
Prevention, engagement, and self-management program in place

Registry used to identify and track hypertension patients
All team members trained in importance of BP goals
All specialties intervene with patients not in control
Evidence-Based Protocol

- 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
Registry of Uncontrolled Patients

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Last Visit</th>
<th>BP at last visit</th>
<th>Return Visit Scheduled Date</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joe Smith</td>
<td>10/1/14</td>
<td>150/90</td>
<td>10/27/14</td>
<td></td>
</tr>
<tr>
<td>Jane Doe</td>
<td>10/15/14</td>
<td>166/102</td>
<td>10/29/14</td>
<td></td>
</tr>
<tr>
<td>Mary Jane</td>
<td>10/2/14</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>10/11/14</td>
<td>144/83</td>
<td>10/31/14</td>
<td>BP is improving. Can return for nurses visit.</td>
</tr>
</tbody>
</table>

- Utilized EMR to automatically add patients whose BP is out of control
- Monitored daily by physicians and nursing staff to ensure all patients have been scheduled for follow up visits
- Allowed for staff to add notes about problems with engaging patients
- Highlighted patients in need of attention
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
Quality Blue Primary Care

- Incentivizes collaboration among providers, patients and employers
- Everyone has “skin in the game” and is motivated to improve health outcomes and lower costs
- The key is .......... getting providers and health systems engaged and focused on efficiency, appropriateness and excellent clinical outcomes.

Care Delivery Innovation: Value-Based Payment

Innovative payment strategies gradually shift accountability for quality outcomes and cost onto provider

Current System (Guaranteed Increase)

Future System (Smaller Guaranteed Increase + Shared Savings + Quality-related Incentives)

PMPM

5%

CPI

Shared Savings

Quality Incentives

Fee Schedule

Fee Schedule

Fee Schedule

Fee Schedule

Fee Schedule

Fee Schedule
Initial Clinical Outcomes Measures

Optimal Diabetes Care
- Blood sugar control
- Cholesterol control
- BP control
- Non-smoker

Optimal Vascular Care
- Cholesterol control
- BP control
- Non-smoker
- Aspirin

Optimal CKD Care
- BP control
- Cholesterol control
- Use of class of medication known to protect kidneys

Healthier Patients

BP control
Rates of Hypertension Control

![Chart showing rates of hypertension control from 2013 to 2018.](chart.png)
THE BOGALUSA HEART STUDY

+40 Years of Hypertension and Cardiovascular Disease Research

Presented by:
Camilo Fernandez, MD, MSc, MBA
Senior Research Scientist | Cardiovascular Disease Center for Lifespan Epidemiology Research
Tulane University School of Public Health and Tropical Medicine
Did you know.....

...that Tulane University is home to one of the most pivotal research studies in the field of hypertension and cardiometabolic diseases, worldwide?
The Bogalusa Heart Study

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.
BOGALUSA, LOUISIANA

Since 1973

BOGALUSA HEART STUDY

1-800-661-6088

985-735-9861

REMEMBER US? Thank you for your lifesaving participation. Please call us if you qualify.
The Bogalusa Heart Study History | Timeline
+40 years of Health Disparities Research

Establishment
1972, Franklinton pilot study

1972-74

SCOR-A
PUNCH CARD
COMPUTER

Special Lipid Studies
1977

Autopsies
1978

EKG Studies
1981

First Family Studies/
Genetic Studies
1982

1975-78

Dietary Studies
1976
Initial Dietary Recalls

Blood Pressure Studies,
High School Follow-ups
1975

1980-88

Ambulatory Blood Pressure
1988

DENTAL STUDIES
1987

ECHOCARDIOGRAM
1981

Only 2 centers were awarded by the NIH—one of them was Bogalusa 1973, The Bogalusa Heart Study began

3-18 age of population

19-32 age of population
The Bogalusa Heart Study History | Timeline

+40 years of Health Disparities Research

Post High School Follow-ups
1992-1996

1992-99

EVOLUTION OF CARDIOVASCULAR RISK WITH NORMAL AGING STUDIES

ECHOCARDIOGRAPHIC FOLLOW-UPS
CAROTID ULTRASOUND
1998

19-35 age of population

2001-10

Genetic/Genomic Association Studies

ECHOCARDIOGRAM
CAROTID ULTRASOUND
NON-INVASIVE VASCULAR STUDIES

36-55 age of population

2013-

Cognitive / Physical Function

Epigenetics

MRI / PET

Microbiome

The Bogalusa Heart Study History
Major Findings by Decade - When the study began, there was almost NO information on heart disease risk factors (blood pressure, body weight, cholesterol, blood sugar, etc.) in childhood, even though it was already the #1 cause of death in the US.

1970s
- The roots of heart disease start in childhood.
- Atherosclerosis (fatty streaks and aortic plaques) could be seen on autopsy in teenagers and young adults who died accidentally.

1980s
- Childhood levels of blood pressure, cholesterol, body weight, blood sugar and insulin resistance predict or “track” into young adulthood and might influence mid-life health.

1990s
- The more childhood risk factors seen (higher weight, blood pressure, cholesterol, etc.), the more CV structure/function alterations are observed on ultrasound imaging of the heart and blood vessels, even when there were absolutely no symptoms among young adults in their 20’s to 30’s.
Findings by Decade (cont’d)

2000s

- Weight at birth impacts atherosclerosis burden in mid-life (30’s to 40’s). This indicates that the roots of heart disease go back even into time during pregnancy, time in utero.
- Telomere length (i.e. the end cap of chromosomes) was different by age, sex, race and heart disease risk factors, suggesting that overall aging processes can be influenced by these.

2010s

- Across race-sex groups, puberty and young adulthood there are critical periods for development of high blood pressure later in life.
- Genes influence heart disease risk factors like body weight and blood pressure from childhood into adulthood.
- Gut microbiome is associated with hypertension and heart disease over the lifespan.
- Temporal relationship of blood pressure during childhood and adolescence with cardiovascular structure and function in adulthood.
Screening for Primary Hypertension in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement*

Virginia A. Moyer, MD, MPH, on behalf of the U.S. Preventive Services Task Force

Description: Update of the 2003 U.S. Preventive Services Task Force (USPSTF) recommendation on screening for high blood pressure in children and adolescents.

Methods: The USPSTF reviewed the evidence on screening and diagnostic accuracy of screening tests for blood pressure in children and adolescents, the effectiveness and harms of treatment of screen-detected primary childhood hypertension, and the association of hypertension with markers of cardiovascular disease in childhood and adulthood.

Population: This recommendation applies to children and adolescents who do not have symptoms of hypertension.

Recommendation: The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for primary hypertension in asymptomatic children and adolescents to prevent subsequent cardiovascular disease in childhood or adulthood.

Evidence

We identified 10 studies that reported on the presence of hypertension (or elevated blood pressure) in children and the presence of hypertension or other intermediate outcomes in adulthood (Table 3, Appendix B). We did not formally quality-rate these studies, though characteristics related to study quality are included in Table 3. Many of the studies had methodological shortcomings, making interpretation and direct comparisons of results difficult. In some studies, it was unclear if blood pressure thresholds in childhood were cohort-specific or based on standardized values.

The definition of hypertension in childhood varied among the studies, with threshold values ranging from >85th percentile to >95th percentile, while three of the studies did not provide a definition of childhood hypertension. The studies drew data from five cohorts: the Bogalusa Heart Study, the Muscatine Study, the Fels Longitudinal Study, the Young Finns Study, and a cohort of children in Boston. The studies reported either the association or diagnostic value of elevated childhood blood pressure in predicting hypertension.
Worldwide Reach
**Our Community**

- **BROTHERS Program:** Brothers Reaching Out to Help Educate on Routine Screenings
- **Church-based Intervention:** for eliminating CV Health Disparities in AA
- **Health Ahead / Heart Smart Health Promotion Program:** Schools
- **Blood Drives**
- **Active Presence in Community Activities**

A "HOW TO" GUIDE FOR IMPLEMENTING A HEALTH PROMOTION PROGRAM
Virtual Clinic In-Home Procedures
VERONICA GILLISPIE-BELL, MD FACOG
Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review
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
Objectives

• Long-term risks for hypertensive disorders in pregnancy
• Louisiana Maternal Mortality Report findings
• The Louisiana Perinatal Quality Collaborative (LaPQC)
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
The rate of hypertensive disorders in pregnancy is rising at a rate higher than that of chronic hypertension.

*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\(^1\)

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

KEY FINDINGS

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

45% were deemed to be preventable
August 2018
Altering Outcomes

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

<table>
<thead>
<tr>
<th>National Findings</th>
<th>Louisiana Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on data from review committees in 9 other states and cities.*</td>
<td>62.5% of hemorrhage deaths were deemed preventable.</td>
</tr>
<tr>
<td>70% of deaths due to hemorrhage were thought to be preventable.</td>
<td>62.5% of cardiomyopathy deaths were deemed preventable.</td>
</tr>
<tr>
<td>68.2% of deaths due to cardiovascular/coronary conditions were thought to be</td>
<td>40% of deaths due to cardiovascular/coronary conditions were deemed preventable.</td>
</tr>
<tr>
<td>preventable.</td>
<td></td>
</tr>
<tr>
<td>66% of deaths occurring within 42 days of pregnancy were thought to be</td>
<td>7 out of 8 deaths due to embolism, including thromboembolism and amniotic fluid</td>
</tr>
<tr>
<td>preventable.</td>
<td>embolism, were deemed not preventable.</td>
</tr>
</tbody>
</table>
KEY FINDINGS

- Top Contributing Factors: Provider and Facility Level
  - Failure to screen/inadequate assessment of risk – 36%
  - Lack of standardized policies and procedures – 13%
  - Lack of referral or consultation – 11%
  - Poor communication/lack of case coordination or continuity of care – 11%
KEY FINDINGS

- 4 black women die for every 1 white woman
- Women age 35 years and older were 6.3 times as likely to die as women under age 25 years
- 62% of women who died had Medicaid insurance.
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 outcomes³
  – [https://implicit.harvard.edu/implicit/takeatest.html](https://implicit.harvard.edu/implicit/takeatest.html)

• **Social determinants of health⁴**
  – Racial residential segregation⁵
  – Health care services
  – Socioeconomic status
  – Healthy behaviors
Change = Improvement + Equity

Neutral
More of the same

Narrowing
Shows improvement

Widening
Gap worsens

Breast Cancer Mortality Among Non-Hispanic Blacks and Non-Hispanic Whites in Chicago: 1990-2005

*Finding Answers: Solving Disparities through Payment and Delivery System Reform; solvingdisparities.org
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
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/preeclampsia** 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

- Respectful Patient Partnership
  - Design for partnership
  - Invest in improvement

- Effective Peer Teamwork
  - 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
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
BTS: Model for Improvement

*Developed by the Associates in Process Improvement. Building on the work of W.E. Deming and Walter Shewhart*
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
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
Our Fundamental Agreements

• Re-center the work to the **who** and the **why**
  – with, not for or to
• 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

DANELLE GUILLORY, MD, PHD
Healthy HeartBeats Program
Rural Health Center
Hypertension Programs

COLLEEN ARCENEAX, MPH
Population Health Manager
Well-Ahead Louisiana,
Louisiana Department of Health / Office of Public Health
Activities to impact heart disease in the clinical setting
Quality Improvement: Focus on NQI Measures
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
Quality Improvement: Focus on NQI Measures

- **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
Quality Improvement: Focus on NQI Measures

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

<table>
<thead>
<tr>
<th></th>
<th>A1c Up to date</th>
<th>Eye Exam annually</th>
<th>Lipid Panel annually</th>
<th>Microalbumin annually*</th>
<th>EKG annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
<td>63%</td>
<td>9%</td>
<td>66%</td>
<td>9%</td>
<td>33%</td>
</tr>
<tr>
<td>Post</td>
<td>75%</td>
<td>19%</td>
<td>62%</td>
<td>36%</td>
<td>41%</td>
</tr>
</tbody>
</table>
Quality Improvement: Focus on NQI Measures

• 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 resulted from 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 EMR. We addressed with the EMR provider and anticipate future improvements”
Million Hearts: Hiding in Plain Sight
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
Million Hearts: Hiding in Plain Sight

• 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
Million Hearts: Hiding in Plain Sight

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

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

• 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
Conclusion

• Clinical sites were critical and invested partners, highly motivated to achieve improvements for their patients.

• Well-Ahead learned key lessons related to our internal capacity to provide practice coaching, which we have enhanced under our new funding with the Population Health Cohort and Regional Practice Coaches.

• The use of EHR is a critical component in making QI work efficient and sustainable and remains a challenge for many clinical sites.

• Patient outcomes were improved by these interventions.
## Almost Lunch

### Logistics – Preparing for Afternoon Workgroups

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider Engagement in Hypertension Management Efforts</strong></td>
<td><strong>Self-Measured Blood Pressure Monitoring Programs with Clinical Support</strong></td>
<td><strong>Clinical - Community Partnerships for Hypertension Management</strong></td>
</tr>
</tbody>
</table>

**ACTION**: Before lunch is over, please add your name to the Sign-up sheet for the Workgroup you plan to attend/engage.
Really Really Close to Lunch

TASTY HEART-HEALTHY LUNCH

For the Low, Low Price of a Group Photo!
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…

<table>
<thead>
<tr>
<th></th>
<th>Provider Engagement in Hypertension Management Efforts</th>
<th>Self-Measured Blood Pressure Monitoring Programs with Clinical Support</th>
<th>Clinical - Community Partnerships for Hypertension Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PROVIDER ENGAGEMENT</td>
<td>SELF-MEASURED BLOOD PRESSURE MONITORING</td>
<td>CLINICAL - COMMUNITY PARTNERSHIPS</td>
</tr>
<tr>
<td>2</td>
<td>IN HYPERTENSION MANAGEMENT EFFORTS</td>
<td>PROGRAMS WITH CLINICAL SUPPORT</td>
<td>FOR HYPERTENSION MANAGEMENT</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Workgroup Objectives

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

Leverage your Partner Profiles which came from the pre-meeting questionnaire.
<table>
<thead>
<tr>
<th>Breakout Workgroups</th>
</tr>
</thead>
</table>
| **1**  
**Provider Engagement**  
in Hypertension Management Efforts  
Chelsea Moreau  
Latraiel Courtney  
Melissa Martin  
Julie Harvill  
John Clymer  
Room (Here) |
| **2**  
**Self-Measured Blood Pressure Monitoring**  
Coretta LaGarde  
Danelle Guillory  
Kaitlyn King  
Kelly Flaherty  
Sharon Nelson  
Room |
| **3**  
**Clinical - Community Partnerships**  
for Hypertension Management  
Colleen Arceneaux  
Brian Burton  
Ashley Hebert  
Erin Leonard  
Julia Schneider  
Room |
# Group Report Outs

**1. Provider Engagement in Hypertension Management Efforts**

- Chelsea Moreau
- Latraiel Courtney
- Melissa Martin
- Julie Harvill
- John Clymer

**2. Self-Measured Blood Pressure Monitoring Programs with Clinical Support**

- Coretta LaGarde
- Danelle Guillory
- Kaitlyn King
- Kelly Flaherty
- Sharon Nelson

**3. Clinical - Community Partnerships for Hypertension Management**

- Colleen Arceneaux
- Brian Burton
- Ashley Hebert
- Erin Leonard
- Julia Schneider

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*Notetakers – Please send your filled-in template to Julie Harvill or John Bartkus!*
Evaluation and Feedback Process

SHARON NELSON
Program Initiatives Manager, Million Hearts® Collaboration
American Heart Association
Wrap Up / Adjourn

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