Welcome and Opening Remarks

JOHN CLYMER
Executive Director
National Forum for Heart Disease & Stroke Prevention

Objectives for Today
1. Identify strategies to increase patient engagement in managing hypertension and hypercholesterolemia
2. Increase awareness of Million Hearts® strategies and activities for 2020
3. Increase stakeholder awareness of the links between hypertension/hypercholesterolemia and co-morbidities such as diabetes and dementia
4. Develop strategies to increase community supports for patient management of hypertension and hypercholesterolemia

Advancing Million Hearts® - Montana Planning Committee

Overview of the Day

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

What does Success Look Like?

Agenda

Engagement & Introductions

JOHN BARTKUS, PMP, CPF
Principal Program Manager
Pensivia
Event Facilitator

Engaging throughout the day on two platforms
Engaging throughout the day

Join at vevox.app
Or search Vevo in the app store
ID: 101-600-725

Alignment and Connections

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

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

Alignment and Connections

Leverage your Partner Profiles which came from the organizational profile survey

Introductions

Introduction Process
* Success requires Change of Approach!
* Let’s see all the Organizations & Participants registered/participating!

Million Hearts® 2022 in Montana Executive Director Update

LAURENCE SPERLING, MD, FACC, FACP, FAHA, FASPC
Executive Director, Million Hearts®
Division for Heart Disease and Stroke Prevention, CDC
Center for Clinical Standards and Quality, CMS
Katz Professor in Preventive Cardiology
Professor of Global Health
Emory University

Our hearts are focused on Millions across the Nation
* Cardiovascular Health and Prevention Remain a Priority
* Million Hearts® in Action
* Updates and Priorities
* Q & A (post your questions via Vevox)

Our world has changed since January 28, 2020

Impact of Pandemic on Cardiovascular Care (4/25/20)

The opinions expressed by the speaker do not necessarily reflect the opinions of the US Department of Health and Human Services, the Public Health Service, the Centers for Disease Control and Prevention, or the Center for Medicare and Medicaid Services.

Dr. Sperling has no conflicts to disclose.

Disclaimer / Disclosure
Executive Director Update

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Current Challenges / Concerns / Gaps in Care

- 118 M Americans living with Hypertension
- Disruption of Ambulatory care
- Need for Medication Access and Adherence
- Impact on lifestyle implementation
- Disruption of cardiac rehabilitation

Implications of Delay and Disruption of Care During the Pandemic

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

COVID-19 & Cardiovascular Disease PSAs

- ACTIVATION TOOLKIT:
  - Emergency Care Focus:
    - Heart Health Focus:
      - COVID-19 & Cardiovascular Disease PSAs

Socioeconomic Status and Cardiovascular Outcomes: Challenges & Interventions

- “In the midst of difficulty lies opportunity …”
  - Albert Einstein
Optimizing Opportunities

- Acceleration of New Care Models
  - Telehealth / telemedicine
- Decreased size of low-value care
- Volume to value transformation
- Healthcare integration / consolidation

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

Relative Event Contributions
to “the Million”

County-level Heart Disease Mortality Across Age Groups, 2017

Million Hearts® Executive Director Update

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  - Q & A (post your questions via Vevox)

Million Hearts® Hospitals & Health Systems Recognition Program

- A new program to recognize institutions working to improve the cardiovascular health of the population & communities they serve by:
  1. Keeping People Healthy
  2. Upgrading Care
  3. Improving Outcomes for Priority Populations
  4. Innovating for Health

- Applicants apply online by October 31, 2020, for the third quarter.
- Million Heart® will publicly recognize top-performing Million Heart® Hospitals and Health Systems

MH® Updates

- CDC-F Campaign (PSA & beyond)
- Million Hearts 1-2-3-4-5 (SG & leverage, 13X events)
- Hypertension Control Champions (116; 15M / 5 M)
- Cardiac Rehabilitation Think Tank
- AMA-AHA Scientific Statement SMBP
- AMA-roadmap.org
- JCRP & JAMA Cardiology invited commentaries
- CMS promotes V-BID in Final Payment Notice for 2021
- Reinvigorating 100 Congregations
- Updated Hypertension Control CHARGE Package

MH® Priorities

- Strategic Planning given current realities - Impact Document
  - Hypertension Control / Priority Populations (SG-CRA: Hypertension Roundtable)
- National Association of Community Health Centers Hypertension Control
- Cholesterol Management - statin videos (1400 / 24 M)
- Initiative focused on Nursing Partnerships (FRSHG fellow)
- Increase uptake and implementation of evidence-based strategies
- Enhance existing internal/external relationships and partnerships

Flu and Cardiovascular Disease

- Studies have shown that flu is associated with an increase of heart attacks and stroke
- Flu vaccination is an AHA/ACC Class 1B Recommendation for Secondary Prevention for patients with cardiovascular disease
- Flu vaccinations have shown to lower heart attacks by 15% to 40% in amateur versus no- vaccination in non-cardiac medication (reduction in therapy)
Influenza (Flu) Burden and Vaccination

- Only 45% of adult Americans received flu vaccine during the 2018-2019 flu season
- There is a significant association between clinician recommendation and vaccination

Influenza (Flu) Burden and Vaccination

Summary

Million Hearts® 2022: Executive Director Update

- Heart disease and stroke remain leading causes of death in U.S.
- Cardiovascular Health and Prevention Must Remain a Priority
- Never a more important time to focus on Millions across the nation
- Commitment to collaboration, partnership, and perseverance

Million Hearts® Resources

- Hypertension Control Change Package, Second Edition
- Self-Measured Blood Pressure Monitoring
- Cholesterol Management
- Medication Adherence
- Cardiac Rehabilitation

A Million Thanks!

More on Million Hearts at Millionhearts.hhs.gov
Reach me at LSperling@cdc.gov
Twitter @MillionHeartsUS

A Million Thanks!

Million Hearts® Hypertension Control Change Package

Lauren E. Owens, MPH
IHRC, Inc. Public Health Analyst
Million Hearts®/Stroke Prevention
Centers for Disease Control and Prevention
September 17, 2020

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Million Hearts® 2022 Priorities

Improving Outcomes for Priority Populations
- Blacks/African Americans
- 35- to 64-year-olds
- People who have had a heart attack or stroke
- People with mental health or substance use disorders who use tobacco

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

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

The Model for Improvement

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

Hypertension Control Change Package (HCCP)
2nd Edition, 2020

Access the Change Package at:
HCCP 2020

• Includes 253 tools from 87 organizations
• Capitalizes on 7 years of MH Hypertension Control Champions
• Features more self-measured blood pressure monitoring (SMBP) resources
• Explores potentially undiagnosed hypertension
• Added new strategies that focus on chronic kidney disease (CKD) testing and identification
• Provides more patient supports for lifestyle modifications

HCCP Format

What Can Public Health Do?

• Share the HCCP with clinical partners; incorporate into QI collaboratives
• Support optimization of HTN management into health care practice
• Share HTN messages on your social media profiles → #MillionHeartsQI
• Speaks with partners about how they can do the same

Appendices – Additional Tools

A. Additional Quality Improvement Resources
B. Hypertension Control Case Studies

Getting to 70% Cardiac Rehabilitation Participation

Haley Stolp, MPH
IHRC, Inc. Public Health Analyst
Million Hearts® Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention
September 17, 2020

Million Hearts® Cardiac Rehabilitation Collaborative Road Map

Million Hearts® Cardiac Rehab Collaborative (CRC)

CR Communications Toolkit

• Infographics, factsheets, hospital case studies
• Patient testimonials on ecards and in YouTube videos
• Social media posts with #CRSavesLives and #CardiacRehabChat
• CR Million Hearts® web content that can be put on your webpage(s)
Million Hearts® / AACVPR
Cardiac Rehabilitation Change Package

AHRQ’s TAKEheart Initiative
Agency for Healthcare Research and Quality’s 3-year, $6M project to increase CR referral, enrollment, and retention.

- Partner Hospitals (n=100) implement automatic referral with care coordination
- Learning Community (n=200) explore strategies from the Change Package and find solutions with other hospitals
- Resource Center for hosting modules, tools, and resources

CR Capacity in the US
If every CR program in the US was filled to capacity, plus 10%, we could only serve ~45% of eligible patients.

Hybrid or Home-based Cardiac Rehabilitation

Proposed Rule by CMS:
Hospital Outpatient Prospective Payment

Assessing Performance and Improving Outcomes

Opportunities to Build Equity in the Delivery of CR

- Automatic referral with care coordination (hint: TAKEheart)
- Offer culturally appropriate enabling services → leverage patient resources, patient ambassadors, and community assets
- Minimize obstacles for participation and reward participation → see strategies in the CR Change Package and/or send us your own
- Employ racially and ethnically diverse CR program staff
- Help eligible hospital employees participate in CR

Thank You!
Haley Stolp, MPH
HStolp@cdc.gov
Contact the Million Hearts® CR Collaborative at millionheartscrc@cdc.gov for questions, comments, or feedback.
Hypertension Status in Montana
Crystelle Fogle, MBA, MS, RD
Division for Heart Disease and Stroke Prevention
CDC

Key BP Focus of Grants
- Undiagnosed HTN
- BP QI
- Team-Based Care
- Medication Therapy Management
- Self-Measured BP Monitoring

Sample Project Outcomes
- 5 CareHere health centers: 161 eligible patients - 32% reassessed - 57% diagnosed with HTN
- 28 Team Up. Pressure Down pharmacies: BP med adherence improved from 71% to 86%
- 8 BP Cuff Loaner Programs: Year 2 (N=47): "% at target" increased from 6% to 34%

Is blood pressure improvement currently a high priority in your organization?
1. Yes
2. No

Poll Question

Barriers

Resources
Supporting Clinical System Changes for Hypertension Control

Jessica Newmyer
American Heart Association
Community Impact Consultant
Jessica.Newmyer@heart.org

Supporting Clinical System Changes for Hypertension Control

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

Building a Culture of Health in Montana

Building a Culture of Health in Montana

Target: BP Can Make A Difference

- The American Heart Association and American Medical Association partnered in 2015 to launch Target: BP nationally to improve blood pressure control and improve heart health by urging medical practices to prioritize blood pressure.

- Target: BP supports physicians and care teams by offering access to the latest research, tools, and resources to reach and sustain blood pressure goal rates within the patient populations they serve.

How Does the Program Work?

1. The American Heart Association and American Medical Association partnered in 2015 to launch Target: BP nationally to improve blood pressure control and improve heart health by urging medical practices to prioritize blood pressure.

2. Target: BP supports physicians and care teams by offering access to the latest research, tools, and resources to reach and sustain blood pressure goal rates within the patient populations they serve.

How Does the Program Work?

1. When first blood pressure measurement taken is elevated or high, take a second confirmatory bp reading.

2. Ensure blood pressure measurement protocols and equipment are in place, including AHA/AMA recommendations on proper positioning of patients for accurate blood pressure control.

3. Implement the protocol and follow blood pressure protocol for all adults and children, including those over 175mg Hg.

4. Positioning posters are placed in every location where blood pressure is taken, reminding employees of the importance of accurate blood pressure measurement.

Target: BP Can Make A Difference

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Measuring Accurately Clinical System Change Examples

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Measuring Accurately

- www.targetbp.org tools and downloads – Measure and Diagnose High BP
- Live virtual trainings and recorded webinars for clinical teams on Measuring Blood Pressure Accurately.
- Educational materials on taking accurate blood pressure measurement for clinical teams including checklists, assessments, posters, etc.
- Consultation on resources and strategies from AHA Community Impact Team

Acting Rapidly

- Implementing the use of ACHIEVE Tools
- Implementing the Heart-healthy Lifestyle Program: Frequent follow-up with hypertension patients.
- Implementation of team-based care
- Implementation of fixed hypertension clinic
- Implementation of standardized treatment algorithm
- Implementation of home-based care

Partnering with Patients and Community

- Implementation of self-monitoring blood pressure programs
- Implementation of self-monitoring blood pressure stations in clinics, lobbies and in community settings
- Implementation of wearable devices for patients enrolled in clinical trials
- Implementation of screenings for food insecurity
- Implementation of standardized referral to local QuitLine

Resources

- www.targetbp.org tools and downloads
- Live virtual trainings and recorded webinars for clinical teams on Acting Rapidly.
- Trainings Include: partnering with patients and community, using SMBP to diagnose and manage BP, etc.
- ASCVD Risk Calculator http://static.heart.org/riskcalc/app/index.html#!/baseline-risk
- Consultation on resources and strategies from AHA Community Impact Team

Register for Target BP:
www.heart.org/RegisterMyOutpatientOrg

Please Contact Jessica Newmyer, AHA Community Impact Consultant, Western States at Jessica.Newmyer@heart.org

2020 Montana Legislative Agenda

- Restrictions on Sales of Flavored Tobacco and Vape Products– Montana and other Communities
- Double SNAP Dollars Program Appropriation – State level request
- Stroke Systems of Care legislation (Requiring Data Collection)– State level request
- Fighting Preemption (protecting local governments and Boards of Health)– State level work
Montana Advancing Million Hearts®

Patty Kosednar

Virtual Workshop
September 17, 2020

Current Initiatives
Through variety of contracts and funding sources...

- Improve behavioral health outcomes, including opioid misuse
- Improve patient safety
- Improve care transitions
- Transition from fee-for-service (FFS) to value-based payment models
- Assist quality reporting (Quality Payment Program’s Merit-based Incentive Payment System [MIPS] and Alternative Payment Model [APM])

Our Approach

- Learning and action networks (LANs)
- Regional approach
- Align requirements, resources, efforts
- Learning and action networks (LANs)
- Patient and family advisory council (PFAC)
- Aligning resources, subject matter experts, outreach and approaches across states and stakeholders

Our Chronic Disease LAN

Mission
A statewide/regional approach, leveraging the combined resources and expertise of participating members to prevent the development and progression of and improve outcomes for
- cardiovascular disease (CVD),
- diabetes (DM),
- chronic kidney disease (CKD),
- and related conditions.

Activities of LAN

- Group education
- Peer-to-peer sharing
- Data collection/analytics
- Identify needs and gaps in care and resources
- Connect subject matter experts where needed
- Identify topics, define scope and deliverables and recruit for working groups
- Provide topics, define scope and deliverables and recruit for working groups
**LAN Events**

**Chronic Disease/COVID-19**

- **August/September:** Hypertension (in progress), Can still register
  
- **October/November:** Diabetes
  
- **January/February:** Chronic Kidney Disease (CKD)

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**Q&A**

- Crystelle Fogle
  - Montana Dept of Public Health & Human Services
- Jessica Newmyer
  - American Heart Association
- Patty Kosednar
  - Mountain-Pacific Quality Health

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**Stretch Break**

2:00 mins

- **James Richards, MD**
  - Stroke Medical Director
  - St. Vincent Healthcare

---

**Hypertension and Dementia**

- JAMES RICHARDS, MD
  - Stroke Medical Director
  - St. Vincent Healthcare

- **Risk factors**
  - Age
  - Race: higher in AA
  - APOE status e4 - single copy 2x risk, both - 10x (women) 2-3%
  - TBI, CTE
  - Stroke

- **Types**
  - Alzheimer disease dementia (AD)
  - Vascular Dementia
  - Lewy Body Dementia
  - FTLDementia

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**Vascular Dementia**

- Small subcortical vascular disease with increase white matter densities and lacunar strokes
  - Compared to AD, shorter life expectancy 5-6 yrs
  - Stroke survivors have 2-2.8 x risk of dementia of all types
  - 1/3 of AD patients have vascular pathology
  - 1/3 of VD have AD pathology

---

**Stroke and Dementia**

- Stroke increases risk of dementia
  - Co-occurrence of AD
  - See increase in AD - reflect of the stroke unmasking AD
  - Autopsy study
    - AD pathology and at least 1 lacunar stroke = 20 times risk of clinical dementia vs AD pathology and no stroke
    - Interaction between stroke and dementia risk, hypertension - make stroke risk factor

---

**Control of BP and Dementia Risk?**

- Framingham Heart Study
  - Cognitive performance over 10-14 year period inversely related to BP
- Honolulu-Asia Aging Study
  - BP control decreases risk later life dementia age

- EVA study
  - Patients with controlled BP had 60% lower risk of cognitive decline noncomersative patients
Control of BP and Dementia Risk

SPRINT-MIND Study
- Intensive BP control < 120 vs <140
- Lower incidence of MCI but not dementia
- Even the control arm had good BP control?

Both logic and most studies support better BP control with lower risk dementia

Q&A

THANK YOU!

James Richards, MD
Stroke Medical Director
SCL Health
St. Vincent

Ask Questions on vevox.app ID: 101-600-725

THANK YOU!

Ask Questions on vevox.app ID: 101-600-725

James Richards, MD
Stroke Medical Director
SCL Health
St. Vincent

Managing Chronic Conditions in a Changing Healthcare Environment

Million Hearts/American Heart Association
September 17, 2020

Eduardo Sanchez, MD, MPH, FAAP, FACC, FACP, FAHA, FASPC
Chief Medical Officer
American Heart Association

Managing Chronic Conditions in a Changing Healthcare Environment

Million Hearts/American Heart Association
September 17, 2020

Eduardo Sanchez, MD, MPH, FAAP, FACC, FACP, FAHA, FASPC
Chief Medical Officer
American Heart Association

Causes of Death: USA (2018)

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<th>Cause</th>
<th>Total (1,000,000)</th>
<th>Total (1,000,000)</th>
<th>Total (1,000,000)</th>
<th>Total (1,000,000)</th>
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<td>Heart diseases</td>
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<tr>
<td>Cancer</td>
<td>539,274</td>
<td>21.1%</td>
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<tr>
<td>Accidents</td>
<td>157,127</td>
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<tr>
<td>Chronic lower resp. Disease</td>
<td>134,466</td>
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<tr>
<td>Stroke</td>
<td>147,810</td>
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<td>5.2%</td>
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<td>Alzheimer's disease</td>
<td>120,018</td>
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<td>Diabetes mellitus</td>
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<td>3.1%</td>
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<td>Influenza/pneumonia</td>
<td>50,170</td>
<td>1.8%</td>
<td>50,170</td>
<td>1.8%</td>
</tr>
<tr>
<td>Kidney disease</td>
<td>51,386</td>
<td>1.8%</td>
<td>51,386</td>
<td>1.8%</td>
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<tr>
<td>Intentional self harm</td>
<td>48,344</td>
<td>1.7%</td>
<td>48,344</td>
<td>1.7%</td>
</tr>
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</table>


AHA Mission Statement

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

Initial Insights

- Characteristics of and important lessons from the COVID-19 Outbreak in China
  - Case Fatality Rates (CFR)/by age and underlying conditions
    - Age 60 or older 14.8%
    - Age 70 – 79 10.0%
    - Cardiovascular disease 10.5%
    - Diabetes 7.5%
    - Hypertension 6.0%


Hypertension

108 million (45%) of adults in the US with hypertension (≥130/80mmHg) or taking blood pressure medications

Race/ethnicity Prevalence (HTN) Prevalence (Controlled)

- Non-Hispanic Whites 46% 32%
- Non-Hispanic Blacks 54% 25%
- Non-Hispanic Asians 39% 19%
- Hispanics 36% 25%

108 million (45%) of adults in the US with hypertension (≥130/80mmHg) or taking blood pressure medications

108 million (45%) of adults in the US with hypertension (≥130/80mmHg) or taking blood pressure medications

Diabetes (2013 – 2016)

26.9 million adults with diagnosed diabetes

11.3 million with undiagnosed diabetes in US

Race/ethnicity Prevalence

- Non-Hispanic Whites 36%
- Non-Hispanic Blacks 56.4%
- Hispanics 39.5%

CDC; National Diabetes Statistics Report 2020. accessed 7/14/2020
Race/ethnicity Prevalence

- Non-Hispanic Whites: 42.2%
- Non-Hispanic Blacks: 49.6%
- Non-Hispanic Asians: 17.4%
- Hispanics: 44.8%

Obesity (2017 – 2018)

People of any age with certain underlying conditions are at increased risk of severe COVID-19

- Chronic kidney disease
- COPD
- Immunocompromised from solid organ transplant
- Obesity (BMI ≥ 30)
- Serious heart conditions (HF, CAD, cardiomyopathies)
- Diabetes mellitus type 1 or 2

COVID-19 Mortality

Compared to White people, the age-adjusted COVID-19 mortality rate for:

- Black people is 3.8 times as high
- American Indian/Alaska Native people is 3.2 times as high
- Pacific Islander people is 2.6 times as high
- Hispanic/Latino people is 2.5 times as high
- Asian people is 1.5 times as high.

COVID-19 and Disproportionality

Socioeconomic factors that may contribute to disproportionality

- “Essential” work
- Crowded, substandard housing conditions
- Underinsurance - No Insurance
- Undocumented residents

Socioeconomic factors that may contribute to disproportionate mortality

- Adequately resourced public health system – federal, state, local
- Health insurance for all – expanded Medicaid
- Tealhealth/telemedicine for medical care and public health

PATIENT ENGAGEMENT IN HYPERTENSION AND CHOLESTEROL MANAGEMENT

ANGELA JENNINGS, RN-BC
Primary Care Nurse Manager
Bozeman Health

RN-Pharmacist Hypertension Clinic
Angela Jennings, RN-BC
September 17, 2020
Bozeman Health strives to improve community health and quality of life by being your partner in health and wellness, compassionately delivering the best care for each person, every time.

RN-Pharmacist Hypertension Clinic

- The RN-Pharmacist Hypertension Clinic started in January 2019.
- The team consists of 8 RNs and Clinical Pharmacists.
- All Practitioners have signed the compact agreement.
- Year to date: 82 patients have participated in the program.
- 82% of the patients are at goal within 6 weeks.
- After graduating, patients receive a follow-up phone call every 3 months for the first year.
- Continue to expand the program.

Our innovative approach!

Celebrating our first birthday

Educational information
- Blood pressure checks
- Drawing for theme basket
- Angel food cake and strawberries
- Sparkling Apple Cider
- Stress-relieving hearts

Motivational Interview

Motivational interviewing is a client-centered, directive method of enhancing intrinsic motivations to change, by exploring and revising ambivalence.

-Miller and Rollnick (2002)

Motivational Interviewing: Definition

Ask Questions on vexox.app
ID: 101-600-725

Patient Engagement

Patient Survey results: 4.8/5
- “I’m so excited to be part of this”
- “This is the push I needed”
- “Lots of attention to detail in a cost-effective manner”
- “I like this program because we have more time to discuss issues”
- “I have a better general understanding and how to approach the future”
Community Outreach & Education

- 2020 Public Presentations
  - MT Pharmacy Association Winter CE & Ski
  - Wisdom and Wine: Hillcrest Senior Living
  - Living Well Online Health Series sponsored by Gallatin County Health Department and Bozeman Health

In summary: Tools and Techniques Used to Improve Patient Engagement

- Develop a cohesive, comprehensive team
- Celebrate success in the form of a birthday
- Utilize those tools already created
- Celebrate success with a surprise gift
- Survey for satisfaction
- Reach out and share with the community

BRIDGING HEALTH & HOME

INTERVENTIONS

- Weekly Bridging Center Clinics
  - On-site programs
  - Assessments
  - Blood pressure, HgbA1C, Glucose
  - Education
  - Referrals
  - Community Health Worker (CHW)
  - Social determinants of health
  - Referrals to community programs
  - Phased

- Community Outreach
  - Faith-based clinics
  - Faith community partners
  - Blood pressure screenings
  - Monthly newsletters
  - Education on health topics
  - Local events/parades

INTERVENTIONS (continued)

Better Choices Better Health

- Evidence-based program that was developed and evaluated at Stanford University
- Self-management Workshops we facilitate
  - Chronic Disease
  - Pain
  - Diet

*Take control of your health
*Tone self-management skills to live life to fullest
*Set your own goals and make a step by step plan to improve your health and life
INTERVENTIONS (CONTINUED)

• Assessing social determinants of health
  - employment
  - housing
  - transportation needs
  - food insecurity
  - financial resource strain

INTERVENTIONS (CONTINUED)

• Community partnerships and collaboration
  - Walk for wellness
  - Partnership with the clinic providers
  - Partnership with community facility that provided a free space to exercise
  - Modeling activity for our patients
  - Cardiac ready community

TRANSITIONS

• Going from Grant funding to Operationalizing
  - CPC+ (Mayville)
    - Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model funded to strengthen primary care through regionally based multi-payer payment reform and care delivery transformation. Practices must have been in operation for at least five years, consistent with the CPC+ promotion of evidence-based, patient-centered, team based care. The CPC+ model aims to improve quality, access, and efficiency of primary care. Practices will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Family Engagement; and (5) Planned Care and Population Health. ND was chosen to participate in the program starting in 2018. It is a 5 year program.

• CCM Billing (Webster)
  - In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for CCM services furnished to Medicare patients with multiple chronic conditions.
  - Care management for chronic conditions including systematic assessment of the patient’s medical, functional, and psychosocial needs; systematic approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.
**Workgroup Objectives**

**What is each organization doing?** What’s working? What isn’t? What can be shared? What’s Next?

**GROUP QUESTIONS - FOR YOUR TOPIC:**
1. What are you doing now? What are the results? (~15 mins)
2. What did you learn today that might influence your direction or support you? (~10 mins)
3. How does patient engagement change as a result of Covid-19? (~10 mins)
4. What challenges/barriers do we have to overcome? (~10 mins)
5. How can we address these challenges? (~15 mins)

**INDIVIDUAL TAKEAWAYS:** (~5 mins)
- What new partners have I identified with whom I can work to further my/their goals?
- What two actions will I take based on what I learned today?

**Workgroup Mechanics**

**Common Themes Report Outs** ~ 5 mins each

**Breakout Session** ~ 65 mins

2:05pm – 2:15pm MT

**PE1**
Main Zoom Room
**PE2**
CS1
CS2

- You've been pre-assigned to a session based on your topic choice.
- In a few moments – you'll see a popup to Join your session.
- At the end of the session, you'll automatically return to the main room. (No need to do anything)

**Breakouts In Progress**

- If you're seeing this slide, it means you're at the main room.
- Let John Bartkus know if you want to join one of the breakout sessions.

**Advancing Million Hearts®**

**Aim**
- Aim to reduce heart disease and stroke

**Partners Working Together in Montana**

**Online Convening** - Sep 17, 2020

**Schedule**

- **2:05pm – Group Reports Begin**
- **2:35pm – Common Strategies/Themes**
- **2:45pm – Next Steps**
- **2:55pm – Final comments / Adjourn**

**AHA and State Heart Disease and Stroke Partners Working Together in Montana**

**Online Convening – Sep 17, 2020**

**Order of Upcoming Report Outs**

- **SHORT BREAK** – while everyone's returning to the main room from breakouts.
- **Group Reports** and at 2:35pm.
- In Break Outs/Session/Questions – please email final notes to be shared on-screen for your group’s report out.

**Order of Report Outs…**

- **PE1**
- **PE2**
- **CS1**
- **CS2**

**Common Strategies and Themes**

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

**Next Steps**

**CRYSTELLE FOGLE, MBA, MS, RD**
Program Manager
Montana Department of Public Health and Human Services

**Adjourn**

**LAURA KING**
Director of Public Health
American Heart Association