

1

## Welcome and Opening Remarks

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

2

### 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

3

### Advancing Million Hearts® - Montana Planning Committee

Member	Organization
Crystelle Fogle	
Mike McNamara	
Carrie Oser	MT DPHHS - Cardiovascular Health Program
Marilyn McLaury	
Patty Kosednar	Mountain-Pacific Quality Health
Amanda Cahill	American Heart Association
Courtney Buys	MT Primary Care Association
Carl Tabler	Woodland Clinic
James DeFoe	PureView Health Center (Community Health Center)
Susan Morgan	Northern Montana Family Medical Center
Karen Gray-Leach	St. Vincent Healthcare

4

## Overview of the Day

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

5



6

### Agenda

8:15 am	• Networking
9:00 am	• Welcome & Overview of the Day • Engagement & Introductions • Million Hearts® 2022 Update • MT Hypertension Initiatives and Resources • Hypertension and Dementia • Managing Chronic Conditions in Changing Healthcare Environment • Patient Engagement in Hypertension & Cholesterol Management • Community Supports for Self-Management of Hypertension and Hypercholesterolemia
12:30 pm	• Lunch (and networking through Zoom private chat)
12:50 pm	• Breakout Sessions • Group Report Outs • Common Themes and Strategies • Next Steps
3:00 pm	• Wrap up / Adjourn @ 3:00pm

7

## Engagement & Introductions


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

8


### Engaging throughout the day on two platforms

9

**Engaging throughout the day**



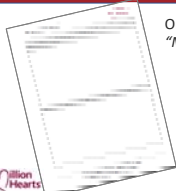
Join at [vevox.app](https://vevox.app)  
Or search **vevox** in the app store  
ID: **101-600-725**



Join: [vevox.app](https://vevox.app) ID: 101-600-725

10

**Alignment and Connections**



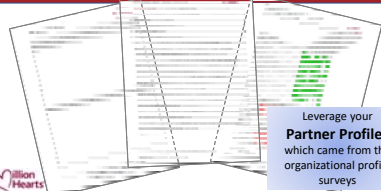
One of the sheets in your packet is "My Alignment Notes"

Opportunities I found to:

- Align with My Organization's work
- Align with Others' work

11

**Alignment and Connections**



Leverage your **Partner Profiles** which came from the organizational profile surveys

12

**Introductions**

**Introduction Process**

- Success requires Change of Approach!
- Let's see all the Organizations & Participants registered/participating!

13

**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

Ask Questions on [vevox.app](https://vevox.app) 101-600-725

14

**Disclaimer / Disclosure**



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.

15

**Million Hearts® Executive Director Update**

- **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)

16

**Our world has changed since January 28,2020**





17

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

By Dr. Sarah Elmer

**Amid the Coronavirus Crisis, Heart and Stroke Patients Go Missing**


Emergency physicians are seeing declines in the number of patients arriving with cardiac problems. Some say they were afraid to go to the hospital.



18

### Million Hearts® Executive Director Update

- 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)




Ask Questions on [vevox.com](#)  
ID: 322-489-324

19

### 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



Khera A, et al. Am J Prev Cardiol 2020;1:1-10

Ask Questions on [vevox.com](#)  
ID: 322-489-324


20

### Impact of Pandemic (MMWR)

In the 18 weeks following the declaration of the COVID-19 national emergency, visits to emergency departments declined for:

- Heart attack: 23%
- Stroke: 20%
- Disruption of high blood sugar: 10%

Hospitalizations were 6 times higher and deaths 31 times higher for COVID-19 patients with reported underlying conditions\*

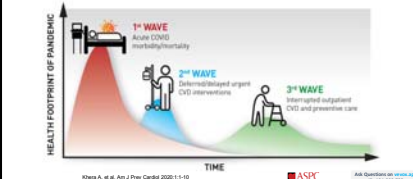


<https://www.cdc.gov/mmwr/index.html>

Ask Questions on [vevox.com](#)  
ID: 322-489-324

21

### Implications of Delay and Disruption of Care During the Pandemic



Khera A, et al. Am J Prev Cardiol 2020;1:1-10


ASPC

Ask Questions on [vevox.com](#)  
ID: 322-489-324

22

### 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 refills and access
  - Inquire about physical activity and nutrition habits
  - Use the full care team to enhance patient care



Khera A, et al. Am J Prev Cardiol 2020;1:1-10

Ask Questions on [vevox.com](#)  
ID: 322-489-324

23

### COVID-19 & Cardiovascular Disease PSAs

**Emergency Care Focus:**

If you experience symptoms of a heart attack or stroke – call 911 immediately

**Heart Health Focus:**

Reach out to your medical team for questions concerns or continued care

**ACTIVATION TOOLKIT:**

1. PSA – TV / YouTube / Twitter / LinkedIn
2. PSA – Facebook / Instagram
3. Social Graphics – Facebook / Instagram
4. Social Post Copy – Standard & Abbreviated
5. Digital Communications Burd
6. COVID-19 & CVD Key Messages




CDC FOUNDATION

COVID-19 & CARDIOVASCULAR DISEASE: PARTNER ACTIVATION TOOLKIT

24

### SMBP – Vital Signs Vital for Telemedicine



Ask Questions on [vevox.com](#)  
ID: 322-489-324

25

### Socioeconomic Status and Cardiovascular Outcomes: Challenges & Interventions

**Low SES**

Poor access to care and healthy foods  
Psychosocial factors  
Behavioral factors  
Environmental factors

**Interventions**


- Behavioral counseling
- Physical activity, smoking, alcohol
- Community-based programs
- Health education
- Local and federal health policy

**Traditional CVD Risk Factors**

Hypertension  
Diabetes  
Lipids  
Smoking  
Obesity  
Poor diet  
Physical inactivity

**Interventions**

- Disease-based care
- Lifestyle modification
- Task shifting




Schultz WM, Kullik RM, Sanderson P, Coughlin AA, Meneah GA, Sperting LS. Circulation. May 2018;137:2160-2178

Ask Questions on [vevox.com](#)  
ID: 322-489-324

26

### “In the midst of difficulty lies opportunity ...”

Albert Einstein



27

### Optimizing Opportunities

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

Poppea A, et al. JACC 2020; 75(3):2989-2991  
Khara A, et al. Am J Prev Cardiol 2020; 1:1-10  
Ask Questions at [www.mh.org](http://www.mh.org)  
800-488-6782

28

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

Ask Questions at [www.mh.org](http://www.mh.org)  
800-488-6782

29

### Relative Event Contributions to "the Million"

Category	Relative Event Contributions (Estimated)
Appoin When Appropriate	~100,000
Blood Pressure Control	~450,000
Cholesterol Management	~350,000
Smoking Cessation	~200,000
Physical Inactivity	~100,000
Sodium Reduction	~150,000

Ask Questions at [www.mh.org](http://www.mh.org)  
800-488-6782

30

### County-level Heart Disease Mortality Across Age Groups, 2017

Ask Questions at [www.mh.org](http://www.mh.org)  
800-488-6782

31

### Million Hearts® Executive Director Update

- 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)

Ask Questions at [www.mh.org](http://www.mh.org)  
800-488-6782

32

### 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. Optimizing Care
  3. Improving Outcomes for Priority Populations
  4. Innovating for Health
- Applicants apply online by **October 31, 2020** for the third quarter.
- Million Hearts® will publicly recognize top-performing Million Hearts® Hospitals and Health Systems

Apply today at <https://millionhearts.org/partners-program/hospitals-health-systems/index.html>

Ask Questions at [www.mh.org](http://www.mh.org)  
800-488-6782

33

### MH® Updates

- CDC-F Campaign (PSA's & beyond)
- Million Hearts 1.0 Addendum (\$5.6 B savings; 135K events)
- Hypertension Control Champions (118; 15M / 5 M)
- Cardiac Rehabilitation Think Tank
- AMA/ AHA Scientific Statement SMBP
- AMA validatebp.org
- JCRP & JAMA Cardiology invited commentaries
- CMS promotes V-BID in Final Payment Notice for 2021
- Reinvigorating 100 Congregations
- Updated Hypertension Control Change Package

Ask Questions at [www.mh.org](http://www.mh.org)  
800-488-6782

34

### MH® Priorities

- Strategic Planning given current realities – Impact Document /
- Hypertension Control / Priority Populations (SG CTA / Hypertension Roundtable)
- National Association of Community Health Centers Hypertension Control / Cholesterol Management- statin videos (1400 / 24 M)
- Initiative focused on Nursing Partnerships (ORISE fellow)
- Increase uptake and implementation of evidence-based strategies
- Enhance existing internal/external relationships and partnerships (Maintain strong partnership with CMS & CMMI) \*\*\*\*Growth of new partnerships

Ask Questions at [www.mh.org](http://www.mh.org)  
800-488-6782

35

### Flu and Cardiovascular Disease

- Studies have shown that flu is associated with an increase of heart attacks and stroke.
- Flu vaccination is an AHA/AACC Class 1B Recommendation for Secondary Prevention for patients with cardiovascular disease
- Flu vaccinations have shown to prevent heart attacks by 15% to 45% (a similar relative risk reduction as other guideline-directed medical therapy)

Ask Questions at [www.mh.org](http://www.mh.org)  
800-488-6782

36

### 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

CDC estimates\* Fall, from October 1, 2018, through April 4, 2020. (Data from CDC)

18,000,000 - 26,000,000 Total Cases  
18,000,000 - 26,000,000 Total Deaths  
475,000 - 740,000 Hospitalizations  
24,000 - 42,000 Deaths

Million Hearts logo and contact information at the bottom.

37

### 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 logo and contact information at the bottom.

38

### Million Hearts® Resources

- Hypertension Control Change Package, Second Edition  
<https://millionhearts.hhs.gov/tools-protocols/action-guides/hccp-change-package/index.html>
- Self-Measured Blood Pressure Monitoring  
<https://millionhearts.hhs.gov/tools-protocols/monitoring.html>
- Cholesterol Management  
<https://millionhearts.hhs.gov/tools-protocols/tools/cholesterol-management.html>
- Medication Adherence  
<https://millionhearts.hhs.gov/tools-protocols/medication-adherence.html>
- Cardiac Rehabilitation  
<https://millionhearts.hhs.gov/tools-protocols/tools/cardiac-rehabilitation.html>

Million Hearts logo and contact information at the bottom.

39

### A Million Thanks!

More on Million Hearts at [Millionhearts.hhs.gov](https://millionhearts.hhs.gov)  
Reach me at [L.Sperling@cdc.gov](mailto:L.Sperling@cdc.gov)  
Twitter @MillionHeartsUS

Million Hearts logo and contact information at the bottom.

40

### Million Hearts® Hypertension Control Change Package

**Lauren E. Owens, 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 logo and contact information at the bottom.

41

### Disclaimer / Disclosure

- Disclaimer:  
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.

Million Hearts logo and contact information at the bottom.

42

### Million Hearts® 2022 Priorities

Keeping People Healthy	Optimizing Care
Reduce Sodium Intake	Improve ABCs*
Decrease Tobacco Use	Increase Use of Cardiac Rehab
Increase Physical Activity	Engage Patients in Heart-healthy Behaviors

**Improving Outcomes for Priority Populations**

Blacks/African Americans
25- to 64-year-olds
People who have had a heart attack or stroke
People with mental health or substance use disorders who use tobacco

Million Hearts logo and contact information at the bottom.

43

### The Model for Improvement

- ← Quality improvement goal(s)
- ← SMART objective(s)
- ← ???
- ← Plan-Do-Study-Act (PDSA) cycles  
– AKA "rapid tests of change"

Million Hearts logo and contact information at the bottom.

44

### Hypertension Control Change Package (HCCP) 2<sup>nd</sup> Edition, 2020

Access the Change Package at:  
<https://millionhearts.hhs.gov/tools-protocols/action-guides/hccp-change-package/index.html>

Million Hearts logo and contact information at the bottom.

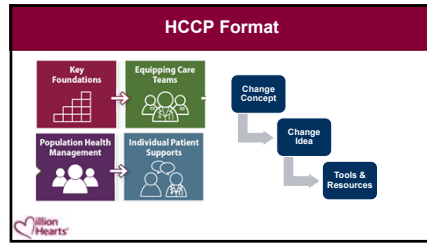
45

### 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

All Questions at [www.mhhearts.org](https://www.mhhearts.org)  
© 2020 All rights reserved.

46



47

### Use Practice Data to Drive Improvement

**Change Concept**

- Determine HTN control and related process metrics for the practice
- Regularly provide a dashboard with BP goals, metrics, and performance

The dashboard shows various metrics including Quality Index - Ambulatory BP Control, with charts and data points for different patient groups.

48

### Appendices – Additional Tools

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

The slide shows several resource cards, including 'Using Data To Tackle Undiagnosed Hypertension and Improve Patient Care' and 'AHRQ Agency for Healthcare Research and Quality'.

49

### 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
- Speak with partners about how they can do the same

The slide includes a screenshot of a 'Hypertension Control CHANGE PACKAGE' document.

50

### Getting to 70% Cardiac Rehabilitation Participation

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

51

### Million Hearts® Cardiac Rehabilitation Collaborative Road Map

Increasing Cardiac Rehabilitation Participation From 20% to 70%: A Road Map From the Million Hearts Cardiac Rehabilitation Collaborative

Phyllis A. Adlin, PhD, Steven J. Katzman, PhD, Janet S. Single, PhD, Loretta E. Haines, PhD, Karen Lee, PhD, MEd, Jennifer Thomas, PhD, Donald S. Stroup, PhD, and Faruk J. Thomas, MD, MS

...Increasing CR participation from 20% to 70% would save 25,000 lives and prevent 180,000 hospitalizations annually in the U.S.

All Questions at [www.mhhearts.org](https://www.mhhearts.org)  
© 2020 All rights reserved.

52

### Million Hearts® Cardiac Rehab Collaborative (CRC)

- Joining efforts to reach 70% CR participation by 2022
- Quarterly calls of reps from ~200 organizations
- CR professionals, health care team members, QI specialists, hospital and health system administrators, public health professionals, payers, and innovators
- Shared 'action plan' of objectives; report progress
  - Increase awareness of the value of CR among health systems, clinicians, patients and families, employers, payers
  - Increase use of best practices for referral, enrollment, and participation
  - Build equity in CR referral, participation, and program staffing
  - Increase sustainability, affordability, and accessibility through innovations in program design, delivery, and payment
  - Measure, monitor, and report progress toward the CRC aim

Email [MillionHeartsCRC@cdc.gov](mailto:MillionHeartsCRC@cdc.gov) to join

All Questions at [www.mhhearts.org](https://www.mhhearts.org)  
© 2020 All rights reserved.

53

### CR Communications Toolkit

- Infographics, factsheets, hospital case studies
- Patient testimonials on eCards and in YouTube videos
- Social media posts with #CRSavesLives and #CardioRehabChat
- CR Million Hearts® web content that can be put on your webpage(s)

The toolkit includes various communication materials such as infographics, factsheets, and patient testimonials.

All Questions at [www.mhhearts.org](https://www.mhhearts.org)  
© 2020 All rights reserved.

54

### Million Hearts® / AACVPR Cardiac Rehabilitation Change Package

Million Hearts® / AACVPR Cardiac Rehabilitation Change Package

System Change, Referral, Enrollment and Retention, Adherence

<https://millionhearts.hhs.gov/health-systems/learn/understanding-change-package/index.html>

ASK Questions on [millionhearts.hhs.gov](https://millionhearts.hhs.gov) 800-488-6926

55

### 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 training modules, tools, and resources

<https://www.ahrq.gov/heart/ahq/>

ASK Questions on [millionhearts.hhs.gov](https://millionhearts.hhs.gov) 800-488-6926

56

### Capturing and Celebrating CR Successes in the US

- Share your CR quality improvement achievements:
  - Send success stories to [MillionHeartsCRC@cdc.gov](mailto:MillionHeartsCRC@cdc.gov) and/or [TAKEheart@ahrq.gov](mailto:TAKEheart@ahrq.gov)
  - Submit story to the American Hospital Association at: <https://www.aha.org/aha/aha-story>
  - Apply to be recognized as a Million Hearts® Hospital: <https://millionhearts.hhs.gov/partners-progress/hospitals-health-systems/index.html>

ASK Questions on [millionhearts.hhs.gov](https://millionhearts.hhs.gov) 800-488-6926

57

### 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.

ASK Questions on [millionhearts.hhs.gov](https://millionhearts.hhs.gov) 800-488-6926

58

### Hybrid or Home-based Cardiac Rehabilitation

Current Paradigm: Traditional CR (No CR, Home CR)

New Paradigm: Traditional CR, Hybrid CR (No CR, Home CR)

ASK Questions on [millionhearts.hhs.gov](https://millionhearts.hhs.gov) 800-488-6926

59

### Proposed Rule by CMS: Hospital Outpatient Prospective Payment

Proposed Rule by the Centers for Medicare & Medicaid Services at 80-022000

ASK Questions on [millionhearts.hhs.gov](https://millionhearts.hhs.gov) 800-488-6926

60

### Assessing Performance and Improving Outcomes

- CR Referral:
  - Outpatient CR referrals (NOF 0643 and CMS 243) and Inpatient CR referrals (NOF 0642)
  - Using Cardiac Rehabilitation Referral Performance Measures in a Quality Improvement System
  - Using Clinical Data Registries to Access Cardiac Rehabilitation Referral Data
- CR Participation:
  - Million Hearts® Outpatient Cardiac Rehabilitation Use Surveillance Methodology (claims-based)
  - Outpatient Cardiac Rehabilitation Participation and Retention From Medicare Beneficiaries
  - Million Hearts® Outpatient Cardiac Rehabilitation Participation and Retention From Medicare Beneficiaries (claims-based)
  - HRFQCR Measurement Years 2020 & 2021 Volume 2

ASK Questions on [millionhearts.hhs.gov](https://millionhearts.hhs.gov) 800-488-6926

61

### Opportunities to Build Equity in the Delivery of CR

- Automatic referral with care coordination (hint: [TAKEheart](https://www.ahrq.gov/heart/ahq/))
- 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](https://millionhearts.hhs.gov) and/or send us your own
- Employ racially and ethnically diverse CR program staff
- Help eligible hospital employees participate in CR

ASK Questions on [millionhearts.hhs.gov](https://millionhearts.hhs.gov) 800-488-6926

62

### Thank You!

Haley Stob, MPH  
[HStob@cdc.gov](mailto:HStob@cdc.gov)

Contact the Million Hearts® CR Collaborative at [MillionHeartsCRC@cdc.gov](mailto:MillionHeartsCRC@cdc.gov) for questions, comments, or feedback.

ASK Questions on [millionhearts.hhs.gov](https://millionhearts.hhs.gov) 800-488-6926

63

## Q&A

**Laurence Sperling, MD, FACC, FACP, FAHA, FASPC**  
Executive Director | [LSperling@cdc.gov](mailto:LSperling@cdc.gov)


**Lauren E. Owens, MPH**  
IHRC, Inc. Public Health Analyst | [LOwens@cdc.gov](mailto:LOwens@cdc.gov)

**Haley Stoip, MPH**  
IHRC, Inc. Public Health Analyst | [HStoip@cdc.gov](mailto:HStoip@cdc.gov)

Million Hearts®  
Division for Heart Disease and Stroke Prevention, CDC


Ask Questions on [vevox.com](#)  
ID: 101-600-725

64



## Hypertension Status in Montana

Crystelle Fogle, MBA, MS, RD



Ask Questions on [vevox.com](#)  
ID: 101-600-725

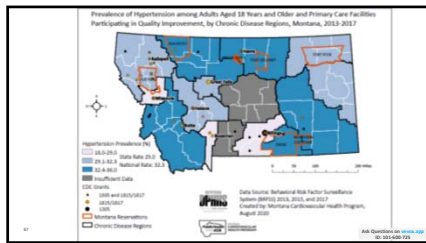
65

## Partners

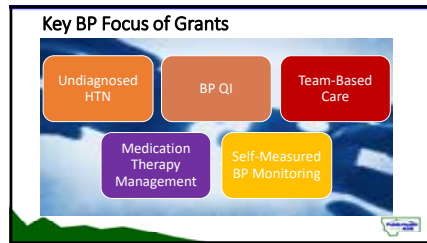



Ask Questions on [vevox.com](#)  
ID: 101-600-725

66






67



68

### Sample Project Outcomes

 <b>5 CareHere health centers:</b> 183 eligible patients - 32% reassessed - 57% diagnosed with HTN	 <b>28 Team Up, Pressure Down pharmacies:</b> - BP med adherence improved from 71% to 86%	 <b>8 BP Cuff Loaner Programs:</b> Year 2 (N=47): - 1% at target* increased from 6% to 34%
--	---	---

Ask Questions on [vevox.com](#)  
ID: 101-600-725

69

### Poll Question


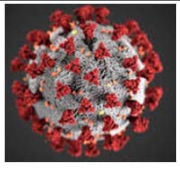
Join: [vevox.app](#) ID: 101-600-725 POLL OPEN

Is **blood pressure improvement** currently a high priority in your organization?

- Yes
- No

Million Hearts

70

## Barriers

Ask Questions on [vevox.com](#)  
ID: 101-600-725

71






## Resources

Ask Questions on [vevox.com](#)  
ID: 101-600-725

72



Public Health 406

Crystelle Fagle  
Cardiovascular Health Program  
ctfagle@mt.gov

73

TARGET: BP

Supporting Clinical System Changes for Hypertension Control

Jessica Newmyer  
American Heart Association  
Community Impact Consultant  
Western States  
[Jessica.Newmyer@heart.org](mailto:Jessica.Newmyer@heart.org)

74

American Heart Association

**Who we are**  
The American Heart 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.

75

Building a Culture of Health in Montana

76

Our levels of work

- Quality, Outcomes, Research and Analytics (Get With The Guidelines) - Paula Hudson, [Paula.Hudson@heart.org](mailto:Paula.Hudson@heart.org)
- Community Impact/Quality Improvement, Ambulatory - Jessica Newmyer, [Jessica.Newmyer@heart.org](mailto:Jessica.Newmyer@heart.org)
- CPE - Mike Dietz, [Mike.Dietz@heart.org](mailto:Mike.Dietz@heart.org)
- Advocacy/Government Relations - Amanda Cahill, [Amanda.Cahill@heart.org](mailto:Amanda.Cahill@heart.org)
- Youth Market - Anne Miller, [Anne.W.Miller@heart.org](mailto:Anne.W.Miller@heart.org)
- Communications - Heather Woodard, [Heather.Woodard@heart.org](mailto:Heather.Woodard@heart.org)

77

Target: BP Can Make A Difference

- The AHA and AMA partnered to launch Target: BP nationally in 2015 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.

78

How Does The Program Work?

- 1 After the participant registers, local AHA staff will work with the organization to:
- 2 Customize a Plan using the M.A.P. Framework
- 3 Measure Improvement & Report Result
- 4 Strive for Recognition ultimately at 70% or higher

79

M.A.P. Framework

- MEASURE blood pressure accurately, every time
- ACT rapidly to address high blood pressure readings.
- PARTNER with patients, families, and communities to promote self-management and monitor progress.

80


Measuring Accurately Clinical System Change Examples

- When first blood pressure measurement taken is elevated or high, take a second confirmation by re-reading.
- Ensure blood pressure measurement protocols are standardized and using AHA/AMA recommendations on proper positioning of patients for accurate blood pressure control.
- Implement into protocol annual refresher training for clinicians on measuring blood pressure accurately.
- Positioning posters are placed in every location where blood pressure measurements are taken to remind clinical team on proper positioning of patients.

81

### Measuring Accurately Resources


- [www.targetbp.org](http://www.targetbp.org) tools and downloads – Measure and Diagnose High BP
- Live virtual trainings and recorded webinars for clinical team 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



82

### Acting Rapidly Clinical System Change Examples

- Implementing the use of ASCVD Risk Calculator into practice
- Implementation into protocols frequent follow-up with hypertensive patients including a timeline for follow up until hypertension is controlled.
- Implementation of standardized treatment algorithm
- Implementation of team-based care



83


### Acting Rapidly Resources

- [www.targetbp.org](http://www.targetbp.org) tools and downloads
- Live virtual trainings and recorded webinars for clinical team on Acting Rapidly.
  - Trainings include: overcoming therapeutic inertia, team-based care, improving bp control through policy, lifestyle interventions for prevention and treatment of hypertension, etc.
- ASCVD Risk Calculator <http://static.heart.org/tkcalc/app/index.html#/baseline-risk>
- Consultation on resources and strategies from AHA Community Impact Team

84

### Partnering with Patients and Community Clinical System Change Examples

- Implementation of self-monitoring blood pressure programs
- Implementation of self-monitoring blood pressure stations in clinic lobbies and in community settings
- Implementation of loaner programs for smbp machines
- Implementation of screenings for food/nutrition insecurity and referral to community resources
- Implementation of fruit and veggie prescriptions with referrals to community resources
- Implementation of standardized referral process to local QuitLine for smoking cessation support



85

### Partnering with Patients and Community Resources

- [www.targetbp.org](http://www.targetbp.org) tools and downloads
- Video for patients teaching them how to take their SMBP measurement
- Example protocols for SMBP monitor loaner programs
- New CPT codes to cover SMBP [https://targetbp.org/tools\\_downloads/new-cpt-codes-to-cover-self-measured-blood-pressure-smbp/](https://targetbp.org/tools_downloads/new-cpt-codes-to-cover-self-measured-blood-pressure-smbp/)
- Live virtual trainings and recorded webinars for clinical team on Acting Rapidly.
  - Trainings include: partnering with patients and community, using SMBP to diagnose and manage bp, etc.
- Consultation on resources and strategies from AHA Community Impact Team

86

**LET'S GET STARTED!**

Register for Target BP:  
[www.heart.org/RequestMuOutpatientOrg](http://www.heart.org/RequestMuOutpatientOrg)


Please Contact Jessica Newmyer, AHA Community Impact Consultant, Western States at [Jessica.Newmyer@heart.org](mailto:Jessica.Newmyer@heart.org)

87

**LET'S GET STARTED!**

Please Contact Jessica Newmyer  
 Community Impact Consultant  
[Jessica.Newmyer@heart.org](mailto:Jessica.Newmyer@heart.org)

Register For Target BP:  
[www.heart.org/REGISTERYOUTRINTENOB](http://www.heart.org/REGISTERYOUTRINTENOB)



88



**American Heart Association  
 Advocacy in Montana**

89

**2020 Montana Legislative Agenda**

- Restrictions on Sales of Flavored Tobacco and Vape Products- Missoula 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



90

EMAIL AMANDA CAHILL,  
GOVERNMENT RELATIONS  
DIRECTOR  
Amanda.cahill@heart.org

AND

SIGN UP FOR RELEVANT MONTANA  
ACTION ALERTS ON  
[YOURETHECURE.ORG/!](http://YOURETHECURE.ORG/)

FOR MORE  
INFORMATION OR TO  
GET INVOLVED:





91

**Mountain-Pacific**  
*Quality Health*

**Montana Advancing  
Million Hearts®**  
Patty Kosednar

Virtual Workshop  
September 17, 2020



92

**About Mountain-Pacific**



Engage providers  
To improve patient care with evidence-based best practices

Encourage collaboration  
Among providers and other community stakeholders

Empower patients  
To take an active role in managing their health


Since 1973

A nonprofit health care improvement organization

93

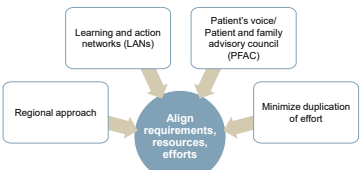
**Current Initiatives**  
Through variety of contracts and funding sources...

- Improve behavioral health outcomes, including opioid misuse
- Increase patient safety
- Improve chronic disease outcomes/ self-management
- Improve care transitions
- Improve nursing home quality
- Implement age-friendly health care systems
- Assist quality reporting (Quality Payment Program's Merit-based Incentive Payment System [MIPS] and Alternative Payment Model [APM])
- Transition from fee-for-service (FFS) to value-based payment models



94

**Our Approach**




Learning and action networks (LANs)

Patient's voice/ Patient and family advisory council (PFAC)

Regional approach


Align requirements, resources, efforts

Minimize duplication of effort



95

**Aligning resources, subject matter experts, outreach and approaches across states and stakeholders**



Hawaii

Montana

Alaska


Wyoming

Guam

American Samoa

96


**Learning and Action Networks (LANs)**



Health care professionals, patients and other stakeholders

Evidence-based, action-oriented agenda

Wide-scale improvement



97

**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.

98

**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
- Identify topics, define scope and deliverables and recruit for affinity group

99

### LAN Events Chronic Disease/COVID-19

August/September: Hypertension (in progress) *Can still register*

October/November: Diabetes

January/February: Chronic Kidney Disease (CKD)

Ask Questions on [civiva.org](#) ID: 101-680-728

100

### QUESTIONS?

Ask Questions on [civiva.org](#) ID: 101-680-728

101

### Q&A

**Crystelle Fogle**  
Montana Dept of Public Health & Human Services

**Jessica Newmyer**  
American Heart Association

**Patty Kosednar**  
Mountain-Pacific Quality Health

Ask Questions on [civiva.org](#) ID: 101-680-728

102

### Stretch Break

2:00 mins

Million Hearts

103

### Hypertension and Dementia

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

Ask Questions on [civiva.org](#) ID: 101-680-728

104

### Dementia

- Risk factors**
  - AGE
  - Race: higher in AA
  - APOE status e4 - single copy 2x risk
  - both - 10 x (women) 2-3%
  - TBI, CTE
  - Stroke
- Types**
  - Alzheimer disease dementia (AD)
  - Vascular Dementia
  - Lewy Body Dementia
  - FTL Dementia

Ask Questions on [civiva.org](#) ID: 101-680-728

105

### 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

Ask Questions on [civiva.org](#) ID: 101-680-728

106

### Stroke and Dementia

- Stroke increases risk of dementia
- Only 60% VD
- See increase in AD - ?effect 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 – main stroke risk factor**

Ask Questions on [civiva.org](#) ID: 101-680-728

107


### Control of BP and Dementia Risk?

- Framingham Heart Study**
  - cognitive performance was inversely correlated with BP over 12-14 year period
- Honolulu-Asia Aging Study**
  - BP control decreased risk later life cognitive decline
- EVA study**
  - patients with controlled BP had same risk of cognitive decline as normotensive patients

Ask Questions on [civiva.org](#) ID: 101-680-728

108

### 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**

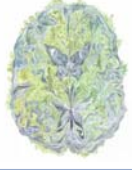
Ask Questions on [Veeva App](#) ID: 101-680-720

109

### Q&A

## THANK YOU!


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




Ask Questions on [Veeva App](#) ID: 101-680-720

110

## Managing Chronic Conditions in a Changing Healthcare Environment



**LAURENCE SPERLING**  
MD, FACC, FACP, FAHA, FASPC  
Executive Director  
Million Hearts®, CDC




**EDUARDO SANCHEZ**  
MD, MPH  
Chief Medical Officer  
American Heart Association

Moderated by  
**JAMES DEFOE, PHARM D**  
Clinical Pharmacist, PureView Health Center

Ask Questions on [Veeva App](#) ID: 101-680-720

111



### Managing Chronic Conditions in a Changing Healthcare Environment

Million Hearts/American Heart Association  
September 17, 2020

**Eduardo Sanchez, MD, MPH, FAAFP**  
Chief Medical Officer for Prevention  
American Heart Association


112

### Causes of Death: USA (2018)

Rank	Cause	Number	Percent
	Total -all causes	2,839,205	100%
1	Heart diseases	655,381	23.1%
2	Cancer	599,274	21.1%
3	Accidents	167,127	5.9%
4	Chronic Lower Resp. Disease	159,486	5.6%
5	Stroke	147,810	5.2%
6	Alzheimer's disease	122,019	4.3%
7	Diabetes mellitus	84,946	3.0%
8	Influenza/pneumonia	59,120	2.1%
9	Kidney disease	51,386	1.8%

Yu QJ, et al. Mortality in Hypertension. *N Engl J Med*. 2019;381(15):1463-1472. National Center for Health Statistics. 2019. [Ask Questions on Veeva App ID: 101-680-720](#)


113



### AHA Mission Statement

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

114




### Initial Insights

- Characteristics of and important lessons from the COVID-19 Outbreak in China
- Case Fatality Rates (CFR) by age and underlying conditions
  - Age 80 or older: 14.8%
  - Age 70 - 79: 8.0%
  - Cardiovascular disease: 10.5%
  - Diabetes: 7.3%
  - Hypertension: 6.0%

Wu, McGoogan. JAMA. 2020. [Ask Questions on Veeva App ID: 101-680-720](#)

115




### Hypertension

108 million (45%) of adults in US with hypertension (≥130mm/80mm) 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%

cdc.gov, accessed 7/14/2020. [Ask Questions on Veeva App ID: 101-680-720](#)

116



### Diabetes (2013 - 2016)

26.9 million adults with diagnosed diabetes  
7.3 million with undiagnosed diabetes in US (21.4%)

Race/Ethnicity	Prevalence
Non-Hispanic Whites	11.9%
Non-Hispanic Blacks	16.4%
Non-Hispanic Asians	14.9%
Hispanics	14.7%

cdc.gov, National Diabetes Statistics Report 2020, accessed 7/14/2020. [Ask Questions on Veeva App ID: 101-680-720](#)

117

### Obesity (2017 – 2018)

Race/Ethnicity	Prevalence
Non-Hispanic Whites	42.2%
Non-Hispanic Blacks	49.6%
Non-Hispanic Asians	19.4%
Hispanics	44.8%

cdc.gov; NCHS, NHANES (2017-2018), accessed 7/14/2020

118

### COVID-19

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)
- Sickle cell disease
- Type 2 DM

cdc.gov; accessed 7/14/2020

119

### COVID-19

People with the following conditions might be at increased risk of severe COVID-19

- Asthma
- Cardiovascular disease
- Cystic fibrosis
- Hypertension
- Other immunocompromising conditions (including HIV or use of corticosteroids)
- Neurologic conditions
- Liver disease
- Pregnancy
- Pulmonary fibrosis
- Smoking
- Thalassemia
- Type 1 DM

cdc.gov; accessed 7/14/2020

120

### COVID-19 and Disproportionality

#### COVID-19 Mortality

- 1 in 1,450 Black Americans has died (69.7 deaths per 100,000)
- 1 in 1,950 American Indian/Alaska Native Americans has died (51.3 deaths per 100,000)
- 1 in 2,450 Pacific Islander Americans has died (40.5 deaths per 100,000)
- 1 in 3,000 Hispanic/Latino Americans has died (33.8 deaths per 100,000)
- 1 in 3,350 White Americans has died (30.2 deaths per 100,000)
- 1 in 3,400 Asian Americans has died (29.3 deaths per 100,000)

<https://www.cdc.gov/research/compare/covid19deaths-by-race/>; accessed 7/14/2020

121

### COVID-19 and Disproportionality

#### 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.

<https://www.cdc.gov/research/compare/covid19deaths-by-race/>; accessed 7/14/2020

122

### COVID-19 and Disproportionality

#### Socioeconomic factors that may contribute to disproportionality

- "Essential" work
- Crowded, substandard housing conditions
- Uninsurance - No insurance
- Underinsurance
- Undocumented residents


123

### Reckoning: Post-COVID Health and Healthcare System

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

124

### PATIENT ENGAGEMENT IN HYPERTENSION AND CHOLESTEROL MANAGEMENT



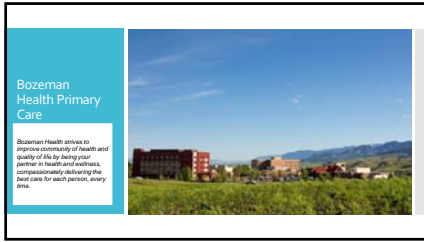
**ANGELA JENNINGS, RN-BC**  
Primary Care Nurse Manager  
Bozeman Health

125

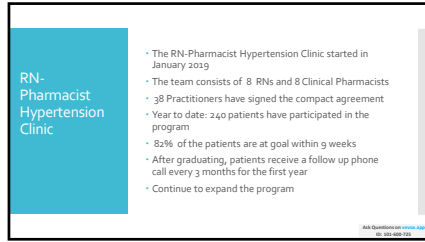
### RN-Pharmacist Hypertension Clinic

Angela Jennings, RN-BC  
Bozeman Health Primary Care  
September 17, 2020

126



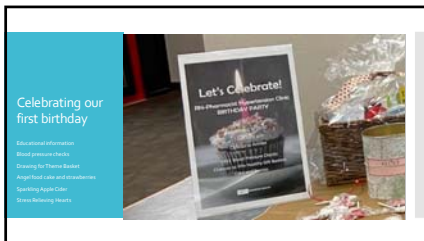
127



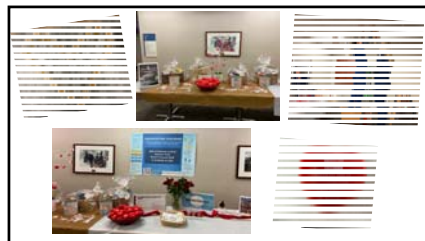
128



129



130



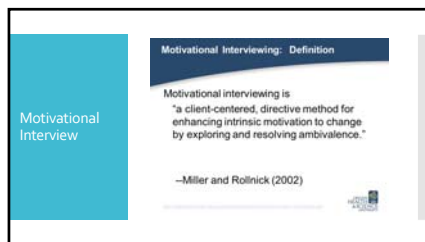
131



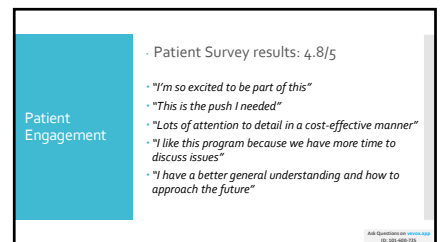
132



133



134



135

**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 City-County Health Department and Bozeman Health

Ask Question on vimeo.com ID: 521-488-774

136

**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

Ask Question on vimeo.com ID: 521-488-774

137

**Questions**




Contact: [ajp@stanford.edu](mailto:ajp@stanford.edu)  
[bozemanhealth.org](http://bozemanhealth.org)

Ask Question on vimeo.com ID: 521-488-774


138

**BRIDGING HEALTH & HOME**

STRATEGIES TO INCREASE COMMUNITY SUPPORTS FOR PATIENT MANAGEMENT OF HYPERTENSION AND HYPERCHOLESTEROLEMIA



AIMEE GROSE, RN  
CLINICAL CARE LEADER



LIBBY KYLLO, BS, RRT  
COMMUNITY HEALTH WORKER

**SANFORD HEALTH**

139

**BRIDGING HEALTH & HOME BACKGROUND**

- Funding and locations
  - Mayville, ND
  - Webster, SD
- Model of Care
  - The Bridging Health and Home program (BHH) is a community-based nurse-led model of care. BHH intertwines the foundations of:
    - Nurse-led community-based clinic
    - Faith Community nursing principles of intentional care of the spirit
    - Evidence-based self-management workshops, Better Choices Better Health

140


**DATA**

- Hypertension
  - Among participants diagnosed with hypertension (78%)
    - 15% increase in individuals average post-enrollment systolic pressures meeting hypertension goal of 140mmHg or less
    - 0.5% increase in individuals average post-enrollment diastolic blood pressure meeting hypertension goal of 90mmHg or less
- Lipid Panel
  - 47% of participants had a pre and post enrollment lipid panel, which of those individuals 32% had attended 2+ visits with the BHH team
    - 5.1% Reduction in LDL
    - 4.5% Reduction in Triglycerides
    - 4.0% Reduction in Cholesterol
    - No significant change noted in HDL

141

**INTERVENTIONS**

- Weekly Bridging Center clinics
  - Core team
    - RN
    - Assessments
    - POC
    - Lipid panel, HbA1C, Glucose
    - Education (verbal and written)
    - Referrals
  - Community Health Worker (CHW)
    - Social determinants of health
    - Referrals to community programs
  - Pharmacist
    - Pill box fills and education




Ask Question on vimeo.com ID: 521-488-774

142

**INTERVENTIONS (CONTINUED)**

- Community Outreach
  - Faith communities
    - Referrals from church leaders on members needing services
    - Speaking after services, along with blood pressure screening
  - Monthly newsletters
  - Education on health topics
  - Local events/parades
    - Winterfest booth
      - BP and lipid panel screening
    - Floats
      - Handing out promotional items and education



Ask Question on vimeo.com ID: 521-488-774

143

**INTERVENTIONS (CONTINUED)**

- Better Choices Better Health
  - Evidence-based program that was developed and researched at Stanford University
  - Self-Management Workshops we facilitate
    - Chronic Disease
    - Pain
    - Diabetes

• Sessions are 2.5 hours, one day a week for 6 consecutive weeks.  
• Held in virtual or community setting

\*Take control of your health  
\*Learn 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

144



**INTERVENTIONS (CONTINUED)**

**Assessing social determinants of health**

- employment
- financial resource strain
- food insecurity
- transportation needs
- lifestyle
- stress
- relationships
- ADLs

145

**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
    - Partnership with the board to provide community education
    - Handouts and flyers made during heart month
    - File of life

146

**TRANSITIONS**

- Going from Grant funding to Operationalizing**
  - CPC+ (Mayville)
    - Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ seeks 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 Caregiver Engagement; and (5) Trained 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; system-based 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.

147

**Questions?**

148

**REFERENCES**

Roles. (2018). Retrieved August 24, 2020, from <http://mnchwalliance.org/who-are-chwcs/roles/>

Long, Kate. "Help Your Community Take Charge of Its Health." SMRC - SMRC, 2020, [www.selfmanagementresource.com/](http://www.selfmanagementresource.com/).

149

**Lunch & Networking**

*Use Zoom Private Chat to Connect*

Meeting Resumes at 12:50 pm

150

**Kickstart to Resume**

**JEN CHILDRRESS**

151

**Afternoon Breakouts / Facilitated Discussions**

**JOHN BARTKUS**  
Principal Program Manager  
Pensavia

152

**Breakout Workgroups**

Breakout Session Topics	Groups
Strategies for Increasing Patient Engagement in managing chronic conditions	PE1, PE2
Strategies for Increasing Community Support for managing chronic conditions	CS1, CS2

2:05pm | 2:15pm MT

Breakout Session ~ 65 mins | Report Outs ~ 5 mins each | Common Themes

153

## 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 those challenges? (~15 mins)

**INDIVIDUAL TAKE-AWAYS:** (~5 mins)

- o What new partners have I identified today with whom I can work to further my/their goals?
- o What two actions will I take based on what I learned today?

154

## Workgroup Mechanics

**Main Zoom Room**

PE1 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)


2:05pm

Breakout Session  
60 mins

2:15pm MT

Report Outs  
3 mins each

Common Themes



155

## Breakouts In Progress

**Main Zoom Room**

PE1 CS1

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


2:05pm

Breakout Session  
60 mins

2:15pm MT

Report Outs  
3 mins each

Common Themes



156

## Advancing Million Hearts<sup>®</sup>

AHA and State Heart Disease and Stroke Partners Working Together in Montana  
Online Convening – Sep 17, 2020

**Order of Upcoming Report Outs**

PE1 CS1

**Schedule**


2:15 pm – Group Reports Begin  
2:35 pm – Common Strategies/Themes  
2:45 pm – Next Steps  
2:55 pm – Final comments / Adjourn

**What's Happening Now?**

**SHORT BREAK** – while everyone's returning to the main room from breakouts.

Group Reports start at 2:15pm. In

**Action:** Group Facilitators/Notetakers – please send [John.Bartkus@heart.org](mailto:John.Bartkus@heart.org) final notes to be shared on-screen for your group's report out.




157

## Group Report Outs

Breakout Session Topics	Groups
Strategies for Increasing Patient Engagement in managing chronic conditions	PE1, PE2
Strategies for Increasing Community Support for managing chronic conditions	CS1, CS2

Order of Report outs...


PE1 PE2 CS1 CS2



158

## Common Strategies and Themes

**JULIE HARVILL, MPA, MPH**  
Operations Manager, Million Hearts<sup>®</sup> Collaboration  
American Heart Association



159

## Next Steps

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



160

## Adjourn

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



161