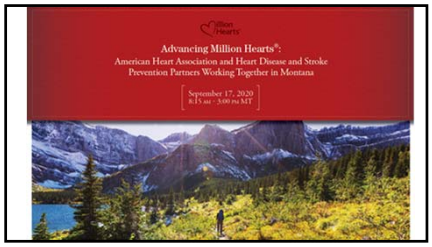

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Welcome and Opening Remarks

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	MT DPHHS - Cardiovascular Health Program
Mike McNamara	
Carrie Oser	
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

What does Success Look Like?

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
12:20 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

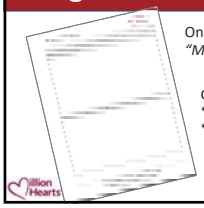
Join at vevox.app

Or search Vevox in the app store

ID: 101-600-725

10

Alignment and Connections

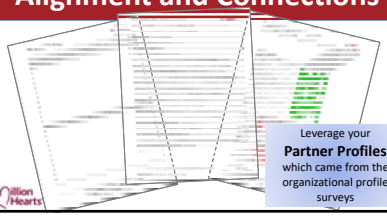


One of the sheets in your packet is *"My Alignment Notes"*

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!

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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

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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.

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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)*

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Our world has changed since January 28,2020

17

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

The New York Times

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.

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Million Hearts® 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

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

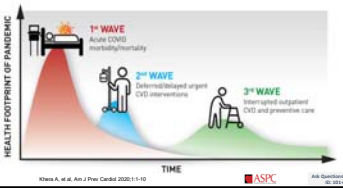
20

Impact of Pandemic (MMWR)

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

21

Implications of Delay and Disruption of Care During the Pandemic



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

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

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COVID-19 & Cardiovascular Disease PSAs

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 Blurb
6. COVID-19 & CVD Key Messages

CDC Foundation

COVID-19 & CARDIOVASCULAR DISEASE: PARTNER ACTIVATION TOOLKIT

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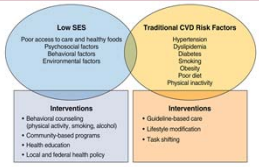
SMBP – Vital Signs Vital for Telemedicine

25

Socioeconomic Status and Cardiovascular Outcomes: Challenges & Interventions



Schultz WM, Kelli HM, Sandesara P, Quyyumi AA, Mensah GA, Sperling LS. Circulation, May 2018;137:2166-2178

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

Poppas A, et al. JACC 2020; 75(3):2989-2991
Khera A, et al, Am J Prev Cardiol 2020;1:1-10

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

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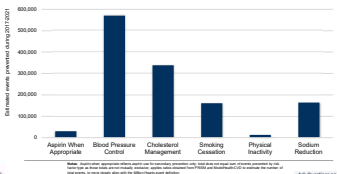
Relative Event Contributions to "the Million"



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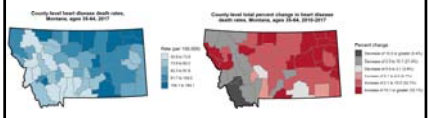
County-level Heart Disease Mortality Across Age Groups, 2017



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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)*

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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.hhs.gov/partners-progress/hospitals-health-systems/index.html

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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

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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

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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 prevent heart attacks by 15% to 45% (a similar relative risk reduction as other guideline-directed medical therapy)

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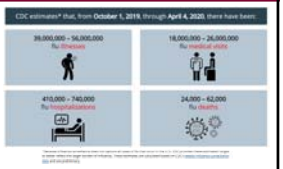
Influenza (Flu) Burden and Vaccination

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



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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

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Million Hearts® Resources

- **Hypertension Control Change Package, Second Edition**
  https://millionhearts.hhs.gov/tools-protocols/action-guides/htn-change-package/index.html
- **Self-Measured Blood Pressure Monitoring**
  https://millionhearts.hhs.gov/tools-protocols/bmbp.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

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A Million Thanks!

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

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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

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Disclaimer / Disclosure

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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
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

*Aspirin use when appropriate, Blood pressure control, Cholesterol management, Smoking cessation

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The Model for Improvement

← Quality improvement goal(s)

← SMART objective(s)

← ???

←Plan-Do-Study-Act (PDSA) cycles – AKA "rapid tests of change"

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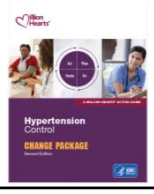
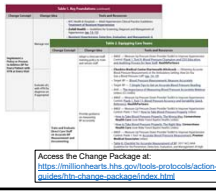
Hypertension Control Change Package (HCCP) 2nd Edition, 2020





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

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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

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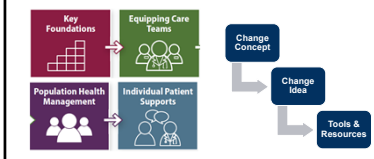
HCCP Format



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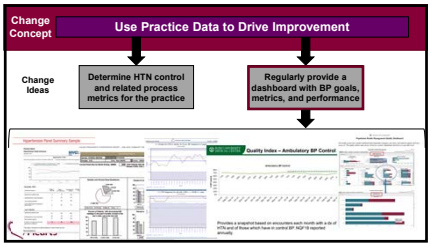

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Appendices – Additional Tools

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

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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

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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

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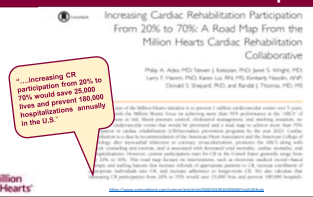
Million Hearts® Cardiac Rehabilitation Collaborative Road Map



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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
  1. Increase awareness of the value of CR among health systems, clinicians, patients and families, employers, payers
  2. Increase use of best practices for referral, enrollment, and participation
  3. Build equity in CR referral, participation, and program staffing
  4. Increase sustainability, affordability, and accessibility through innovations in program design, delivery, and payment
  5. Measure, monitor, and report progress toward the CRC aim

Email MillionHeartsCRC@cdc.gov to join

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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)

https://millionhearts.hhs.gov/partners-progress/partners/cardiac-rehab-toolkit.html

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Million Hearts® / AACVPR Cardiac Rehabilitation Change Package

https://millionhearts.hhs.gov/tools-protocols/action-guides/cardiac-change-package/index.html

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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.takeheart.ahrq.gov/

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Capturing and Celebrating CR Successes in the US

- **Share your CR quality improvement achievements:**
  - Send success studies to MillionHeartsCRC@cdc.gov and/or TAKEheart@abtassoc.com.
  - Submit story to the American Hospital Association at: https://www.huddleforcare.org/submit-a-story/
  - Apply to be recognized as a Million Hearts® Hospital: https://millionhearts.hhs.gov/partners-progress/hospitals-health-systems/index.html

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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.

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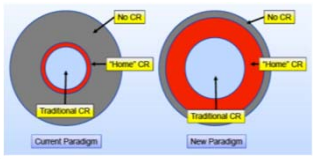
Hybrid or Home-based Cardiac Rehabilitation



Olson, T. Balancing Technology with the Human Touch to Promote Exercise is Medicine. AACVPR 2018

59

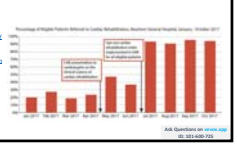
Proposed Rule by CMS: Hospital Outpatient Prospective Payment

https://www.federalregister.gov/documents/2020/08/12/2020-17086/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

60

Assessing Performance and Improving Outcomes

- CR Referral:
  - Outpatient CR referrals (NQF 0643 and CMS 243) and Inpatient CR referrals (NQF 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)
    - Tracking Cardiac Rehabilitation Participation and Completion Among Medicare Beneficiaries to Inform the Efforts of a National Initiative (2018-2017)
  - HEDIS® Measurement Years 2020 & 2021, Volume 2



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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

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Thank You!

Haley Stolp, MPH
HStolp@cdc.gov

Contact the Million Hearts® CR Collaborative at millionheartscrc@cdc.gov for questions, comments, or feedback.

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Q&A

Laurence Sperling, MD, FACC, FACP, FAHA, FASPC
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Lauren E. Owens, MPH
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Haley Stolp, MPH
IHRC, Inc. Public Health Analyst HStolp@cdc.gov

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

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Hypertension Status in Montana

Crystelle Fogle, MBA, MS, RD

Montana Chronic Disease Prevention & Health Promotion Bureau

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Partners

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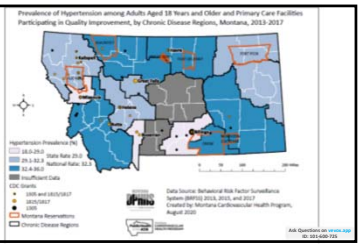

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Key BP Focus of Grants

- Undiagnosed HTN
- BP QI
- Team-Based Care
- Medication Therapy Management
- Self-Measured BP Monitoring

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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%

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Poll Question

Join: vevox.app ID: 101-600-725 POLL OPEN

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

1. Yes
2. No

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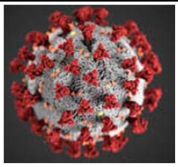

Barriers

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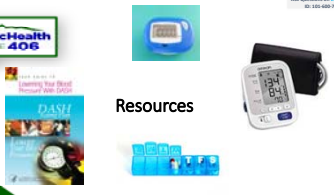
Resources



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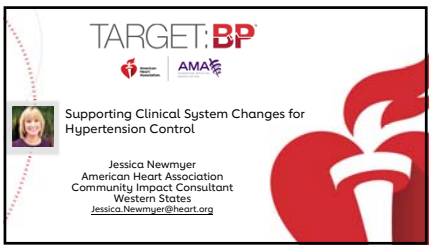

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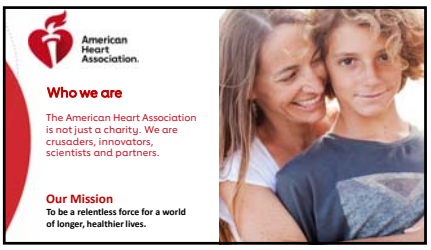

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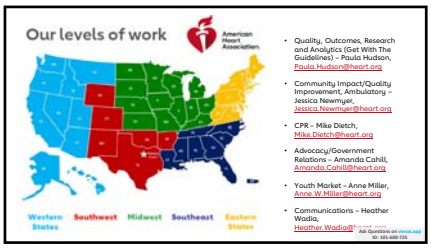

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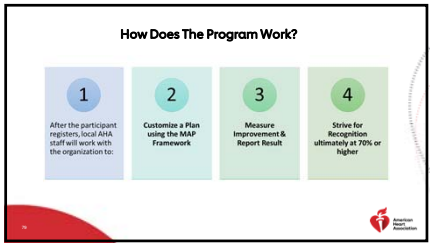

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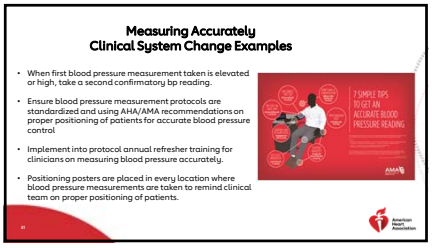

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Measuring Accurately Resources

- 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

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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

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Acting Rapidly Resources

- 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/riskcalc/app/index.html#!/baseline-risk
- Consultation on resources and strategies from AHA Community Impact Team

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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

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Partnering with Patients and Community Resources

- 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/
- 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

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

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

87

Please Contact Jessica Newmyer
Community Impact Consultant
Jessica.Newmyer@heart.org

Register For Target BP:
WWW.HEART.ORG/REGISTERMYOUTPATIENTORG

LET'S GET STARTED!

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American Heart Association Advocacy in Montana

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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

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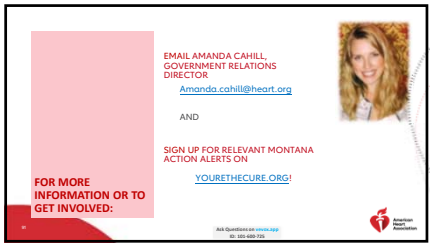

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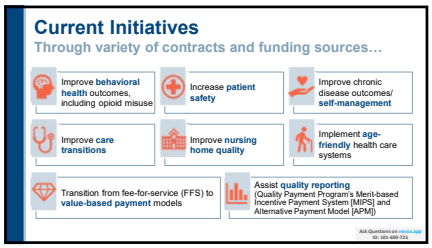

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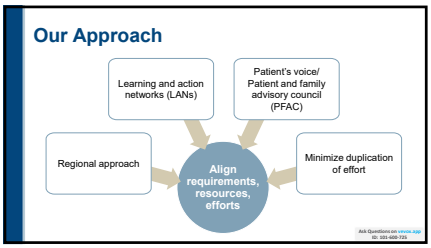

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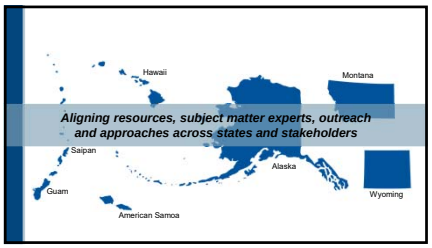

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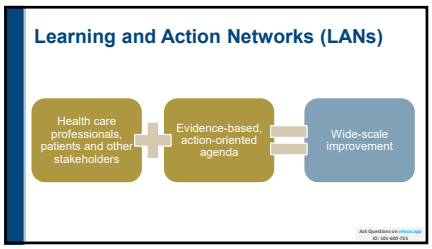

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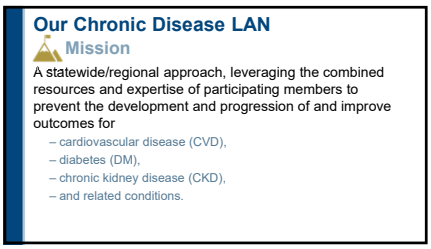

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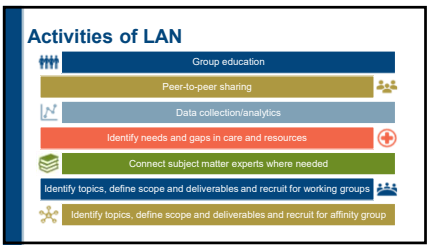

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LAN Events
Chronic Disease/COVID-19

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

October/November — **Diabetes**

January/February — **Chronic Kidney Disease (CKD)**

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Mountain-Pacific Quality Health

QUESTIONS?

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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

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Hypertension and Dementia

JAMES RICHARDS, MD
Stroke Medical Director
St. Vincent Healthcare

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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

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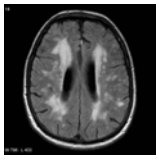
Vascular Dementia

- 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



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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**

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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

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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**

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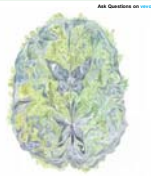
Q&A

THANK YOU!

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



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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, PharmD
Clinical Pharmacist, PureView Health Center

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American Heart Association

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

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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..%
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%

Xu JQ, et al. Mortality in the United States, 2018. NCHS Data Brief, no 355. National Center for Health Statistics. 20..

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AHA Mission Statement

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

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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.

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

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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

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Obesity (2017 – 2018)

Race/ethnicity	Prevalence
Non-Hispanic Whites	42.2%
Non-Hispanic Blacks	49.6%
Non-Hispanic Asians	17.4%
Hispanics	44.8%

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

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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

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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

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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.apmresearchlab.org/covid/deaths-by-race; accessed 7/14/2020

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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.apmresearchlab.org/covid/deaths-by-race; accessed 7/14/2020

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COVID-19 and Disproportionality

Socioeconomic factors that may contribute to disproportionality

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

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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

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PATIENT ENGAGEMENT IN HYPERTENSION AND CHOLESTEROL MANAGEMENT

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

Million Hearts®

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RN-Pharmacist Hypertension Clinic

Angela Jennings, RN-BC
Bozeman Health Primary Care

September 17, 2020

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Bozeman Health Primary Care

Bozeman Health strives to improve community of health and quality of life by being your partner in health and wellness, compassionately delivering the best care for each person, every time.

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RN-Pharmacist Hypertension Clinic

- The RN-Pharmacist Hypertension Clinic started in January 2019
- The team consists of 8 RNs and 8 Clinical Pharmacists
- 38 Practitioners have signed the compact agreement
- Year to date: 240 patients have participated in the program
- 82% of the patients are at goal within 9 weeks
- After graduating, patients receive a follow up phone call every 3 months for the first year
- Continue to expand the program

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RN-Pharmacist HTN Clinic & Patient Engagement

Our innovative approach!

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Celebrating our first birthday

- Educational information
- Blood pressure checks
- Drawing for Theme Basket
- Angel food cake and strawberries
- Sparkling Apple Cider
- Stress Relieving Hearts

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RN-Pharmacist HTN Tools

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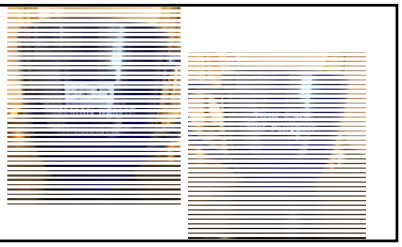

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Motivational Interview

Motivational Interviewing: Definition

Motivational interviewing is
"a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence."

–Miller and Rollnick (2002)

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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"*

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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

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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

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Questions

Contact:
sjennings@bozemanhealth.org

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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

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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

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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

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INTERVENTIONS

- **Weekly Bridging Center clinics**
  - Core team
    - RN
      - Assessments
      - POCT
        - Lipid panel, HgbA1C, Glucose
      - Education (verbal and written)
      - Referrals
    - Community Health Worker (CHW)
      - Social determinants of health
      - Referrals to community programs
    - Pharmacist
      - Pill box fills and education

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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

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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

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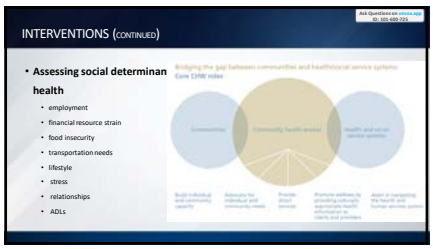

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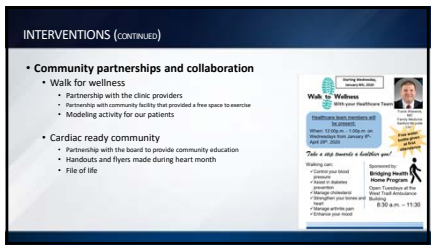

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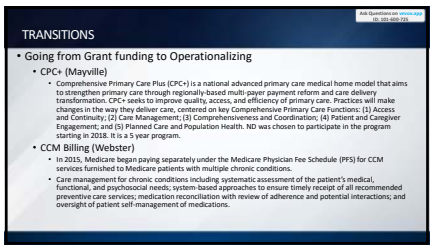

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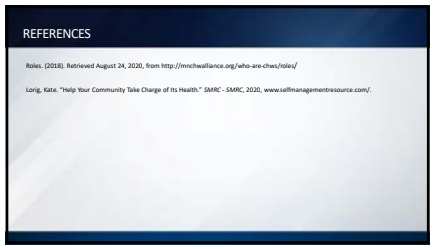

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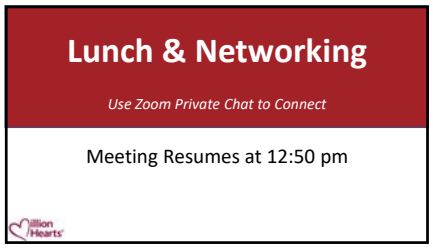

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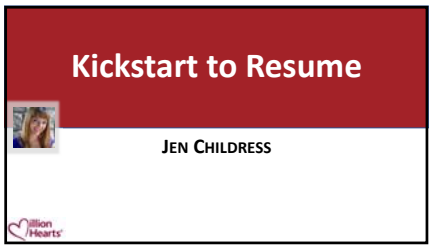

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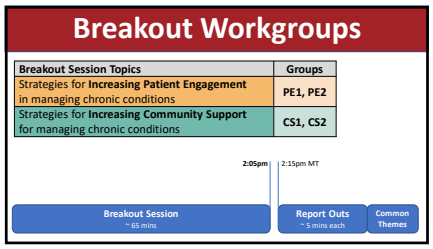

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Workgroup Objectives

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)

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

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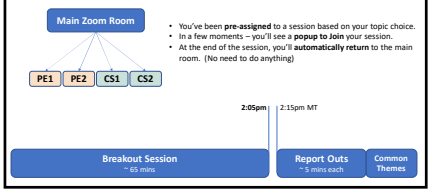
Workgroup Mechanics



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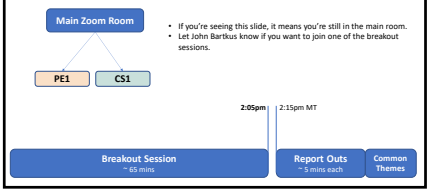
Breakouts In Progress



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Advancing Million Hearts®

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 t.john.Bartkus@heart.org final notes to be shared on-screen for your groups' report out.

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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

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Common Strategies and Themes

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

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Next Steps

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

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Adjourn

LAURA KING
Director of Public Health
American Heart Association

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