1

Welcome and Opening Remarks

LAURA KING
Director of Public Health
American Heart Association

2

Objectives for Today

- Increase awareness of Million Hearts® strategies and activities for 2020 (so you are aware of additional tools and resources to support this effort)
- Develop strategies for increasing patient engagement and activation in hypertension self- management
- Identify opportunities to collaborate with community partners to address patients' social and economic needs (to enable them to better manage their health conditions)
- Develop strategies to maximize patient visits to support hypertension management

3

Advancing Million Hearts® - South Carolina Planning Committee

Valerie Bridges, Sarah Cockrell, Vonda Evans, Nora Farrell, Dom Francis, Julie Harvill, Kacie Kennedy, Crystal Kirkland, Kayla Kranenberg, Brennan Meagher, Sharon Nelson, Nate Patterson, Katherine Plunkett, Katie Schumacher, Annie Thornhill, Kelly Wilkins, La'Shanda Wood

South Carolina Department of Health and Environmental Control, Division of Diabetes and Heart Disease Management

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Overview of the Day

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

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Agenda

8:15 am	• Networking
9:00 am	• Welcome & Overview of the Day • Engagement & Introductions • Million Hearts® 2022 Update • SC Hypertension Initiatives and Resources
	• Patient Engagement in Hypertension Self-Management • Collaborating with Community Partners to Address Patients Social and Economic Needs • Maximizing Patient Visits to Support Hypertension Management • Integrating Community Health Workers into Team-based Care
12:00 pm	• Lunch *(and networking through Zoom private chat)*
	• Breakout Sessions
	• Group Report Outs • Common Themes and Strategies • Next Steps
3:00 pm	• Wrap up / Adjourn @ 3:00pm

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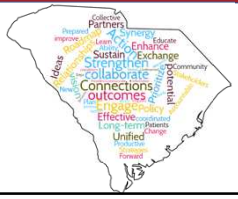
What does Success Look Like?



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Engagement & Introductions

JOHN BARTKUS
Principal Program Manager
Pensivia

Event Facilitator

8

Engaging throughout the day

zoom Meeting

Audio/Video/Presentations
Recommend Video OFF in the Morning and ON for the Breakout Sessions
You can adjust side by side

vevox

Use on separate device, if possible (phone, 2nd monitor)
Polls and Q&A

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Engaging throughout the day

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Audience Engagement

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Million Hearts®

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Where are you joining from today?

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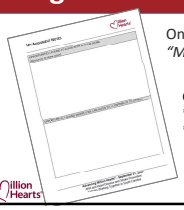
Alignment and Connections



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

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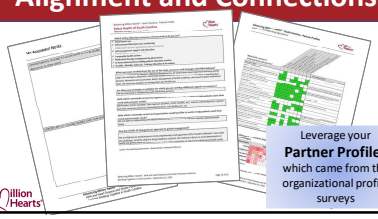
Alignment and Connections



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

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Introductions

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

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Million Hearts® 2022 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

Million Hearts®

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Disclaimer/Disclosure

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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
- Discussion / Q & A- following update on HCCP

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Our world has changed since January 28, 2020

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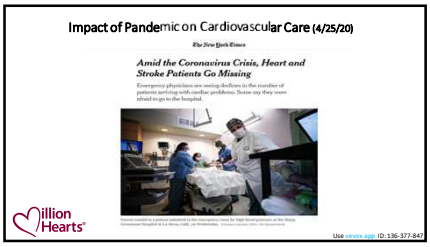
Impact of Pandemic on Cardiovascular Care (4/25/20)



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Million Hearts® Executive Director Update

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- Million Hearts® in Action
  - Updates and Priorities
- Discussion / Q & A

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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

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Impact of Pandemic (MMWR)

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

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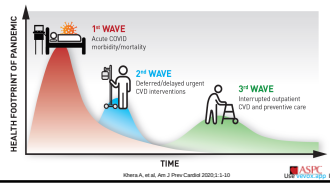
Implications of Delay and Disruption of Care During the Pandemic



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

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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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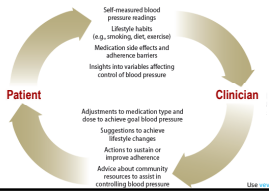
SMBP- Vital Signs Vital for Telemedicine



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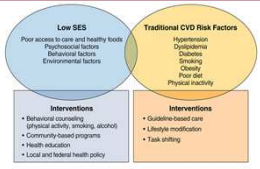
Socioeconomic Status and Cardiovascular Outcomes: Challenges & Interventions



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

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"In the midst of difficulty lies opportunity …"

Albert Einstein

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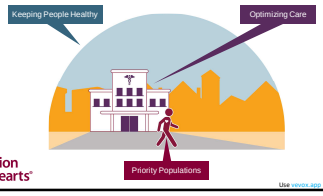
Million Hearts® 2022 Aim:
Prevent a Million Heart Attacks and Strokes in Five Years



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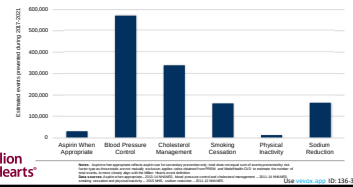
Relative Event Contributions to "the Million"



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Million Hearts® Executive Director Update

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- **Million Hearts® in Action**
  - **Updates and Priorities**
- Discussion / Q & A- following update on HCCP

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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 **July 31, 2020** for the second 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

CDC estimates* that, from **October 1, 2019**, through **April 4, 2020**, there have been:

39,000,000 – 56,000,000 flu illnesses	18,000,000 – 26,000,000 flu medical visits
410,000 – 740,000 flu hospitalizations	24,000 – 62,000 flu deaths

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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

- **2020 American Heart Month: *We've got this!*** https://www.cdc.gov/heartdisease/american_heart_month.htm
- **Self-Measured Blood Pressure Monitoring** https://millionhearts.hhs.gov/tools-protocols/smbp.html
- **Medication Adherence** https://millionhearts.hhs.gov/tools-protocols/medication-adherence.html
- **Cardiac Rehabilitation** https://millionhearts.hhs.gov/tools-protocols/tools/cardiac-rehabilitation.html
- **Healthy Is Strong** https://millionhearts.hhs.gov/learn-prevent/healthy-is-strong.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 1, 2020

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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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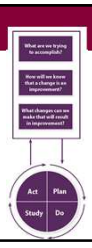
The Model for Improvement



← 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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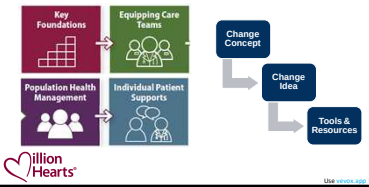
HCCP Format



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Use Practice Data to Drive Improvement

Change Concept

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Use Practice Data to Drive Improvement

Change Concept

Change Ideas

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

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Use Practice Data to Drive Improvement

Change Concept

Change Ideas

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

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Appendices – Additional Tools

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

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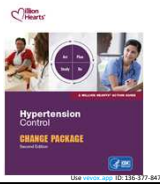
What Can Public Health Do?

- 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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Q&A

Laurence Sperling, MD, FACC, FACP, FAHA, FASPC
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LSperling@cdc.gov

Lauren E. Owens, MPH
IHRC, Inc. Public Health Analyst, Million Hearts®
LOwens@cdc.gov

Division for Heart Disease and Stroke Prevention, CDC

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South Carolina Hypertension Initiatives and Resources

Katherine Plunkett	Vonda Evans	La'Shanda Wood
Sr. Manager South Carolina Primary Health Care Association	Community Impact Director American Heart Association	Health Systems Specialist South Carolina Dept of Health & Environmental Control

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SOUTH CAROLINA PRIMARY HEALTH CARE ASSOCIATION

Access to Quality Health Care for all of South Carolina

South Carolina Primary Health Care Association

Katherine Plunkett, LMSW, MPH
Senior Manager of Clinical Quality Improvement
South Carolina Primary Health Care Association

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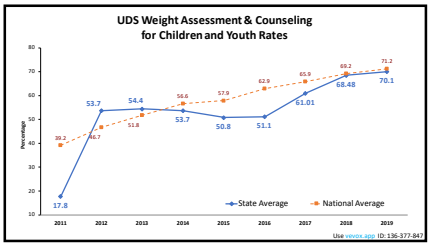

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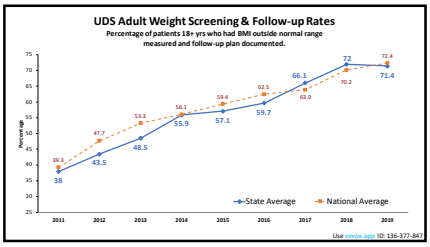

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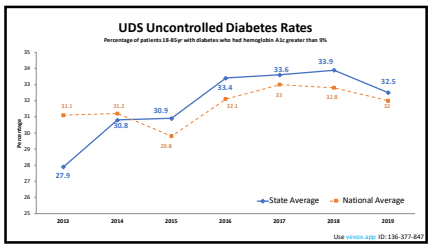

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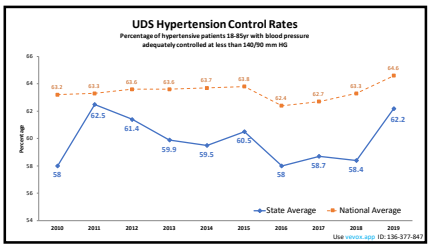

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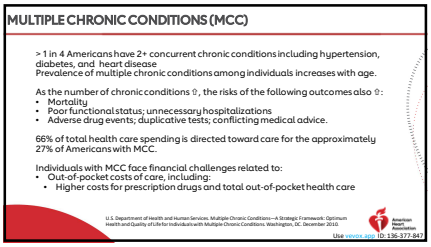

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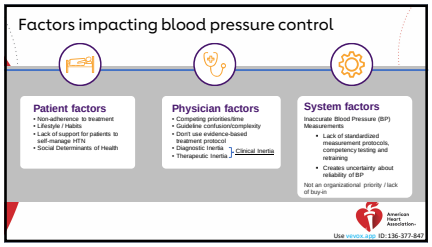

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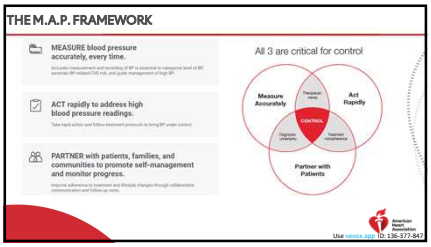

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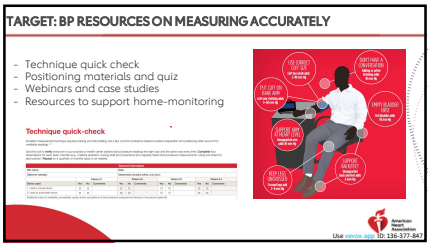

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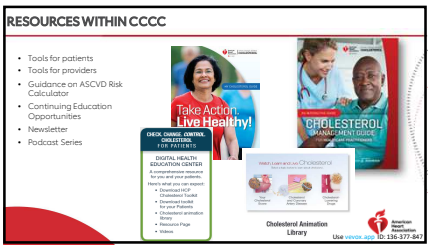

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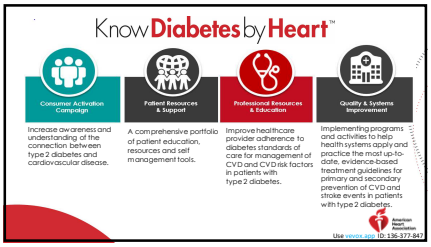

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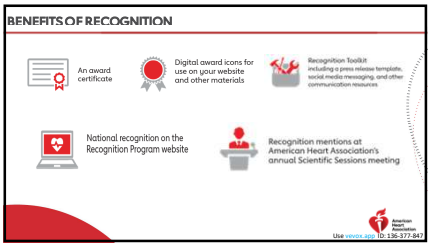

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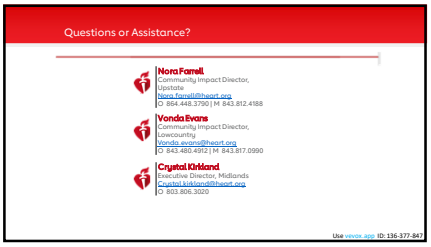

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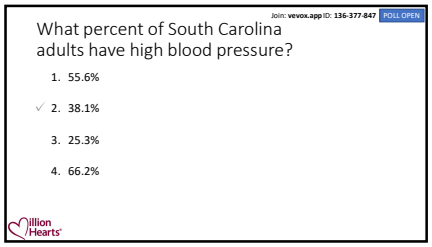

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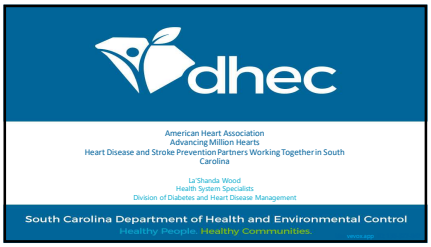

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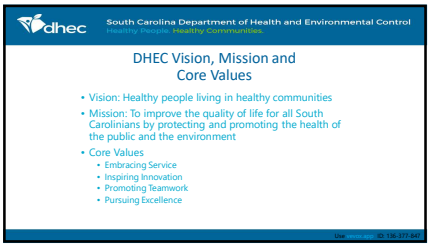

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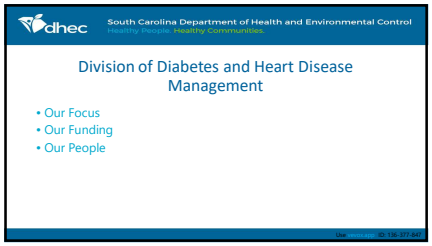

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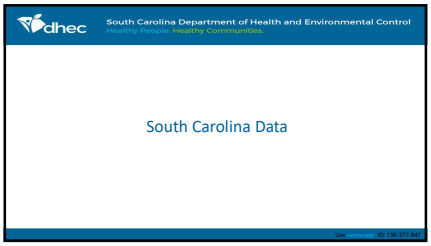

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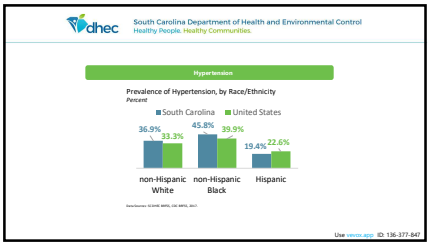

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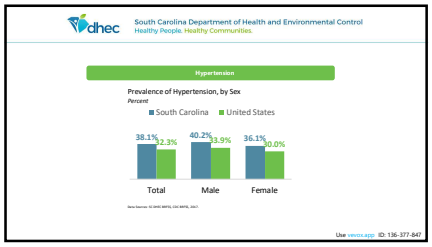

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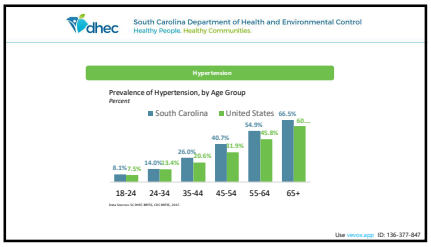

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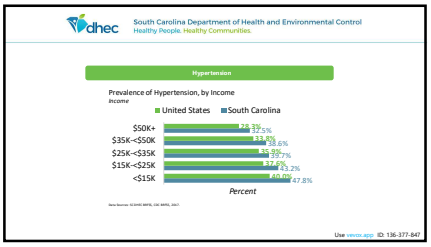

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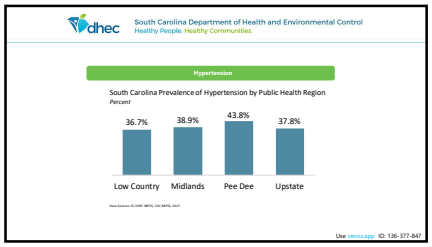

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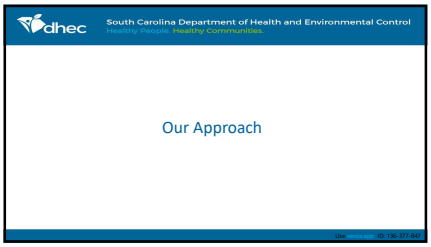

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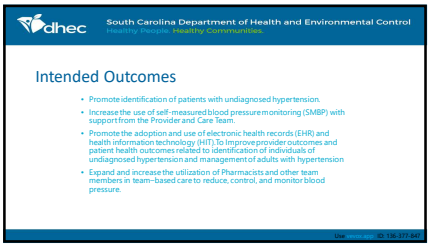

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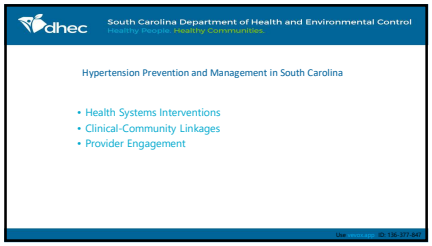

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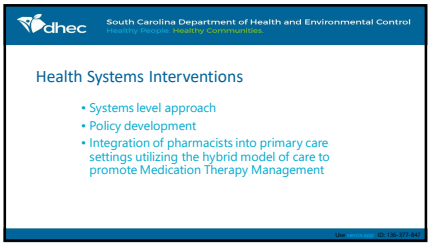

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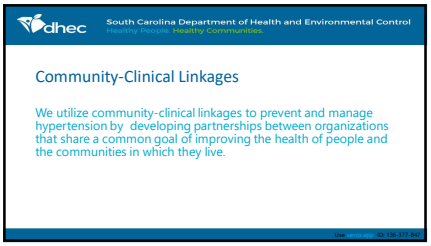

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South Carolina Department of Health and Environmental Control
Healthy People. Healthy Communities.

Provider Engagement

- Successfully engaging providers and their staff can have a dramatic impact on the patient provider health experience
- Involved providers lead to improved clinical outcomes

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South Carolina Department of Health and Environmental Control
Healthy People. Healthy Communities.

Collaborative Partners

92

South Carolina Department of Health and Environmental Control
Healthy People. Healthy Communities.

Partners in Hypertension Prevention and Management

- Centers for Disease Control and Prevention (CDC)
- South Carolina Pharmacy Association (SCPhA)
- South Carolina Primary Healthcare Association (SCPHCA)
- South Carolina Office of Rural Health (SCORH)
- The American Society of Hypertension (ASH)
- The American Heart Association (Advancing Million Hearts)
- South Carolina Alliance of YMCAs

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South Carolina Department of Health and Environmental Control
Healthy People. Healthy Communities.

CONTACT US

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Q&A

Combined

Katherine Plunkett	Vonda Evans	La'Shanda Wood
Sr. Manager South Carolina Primary Health Care Association	Community Impact Director American Heart Association	Health Systems Specialist South Carolina Dept of Health & Environmental Control

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Stretch Break

2:00 mins

96

Develop strategies for increasing patient engagement and activation in hypertension self-management

DANIEL T. LACKLAND, DRPH, FACE, FAHA
Medical University of South Carolina

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Disclosures

- Member of NHLBI Risk Assessment Workgroup
- Member of 2014 Hypertension Guidelines (JNC 8)
- Member of Evidence Rating Committee for ACC/AHA Hypertension Guidelines
- **No financial disclosures**

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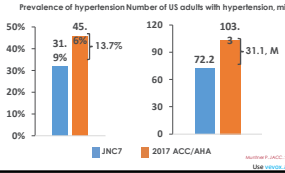
IMPACT: PREVALENCE OF HYPERTENSION – 2017 ACC/AHA AND JNC7 GUIDELINES



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Use out-of-office BP measurements to confirm the diagnosis of hypertension and to titrate antihypertensive medication in conjunction with telehealth counseling or clinical interventions.

- Using a combination of office and out-of-office BP measurements, several useful BP patterns can be discerned.
- Data indicate that masked hypertension and masked uncontrolled hypertension are associated with high risk of CVD and mortality.
- Likewise, telehealth can be employed with valid out of clinic blood pressure vales.

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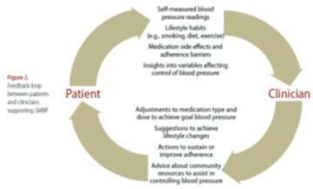

Centers for Disease Control and Prevention. Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2013.

101

Home Blood Pressure Monitoring

- HBPM can be used to detect white-coat hypertension and masked hypertension.
- Many HBPM devices available for purchase have not been validated, and **only validated devices should be recommended for HBPM.**
- HBPM is effective in reducing BP when used in combination with supportive interventions (eg, web/telephone feedback).
- Patients should be encouraged to use HBPM devices that automatically store BP readings in memory or transmit BP readings to a healthcare provider

Hypertension. 2019;73:e35–e66.

102

Patient training provided by healthcare staff or providers

- Provide information about **hypertension diagnosis and treatment**
- Provide information on the **proper selection of a device**
- Provide instruction on **how patients can measure their own BP**
- Provide instruction that the **HBPM device and BP readings should be brought to healthcare visits**
- Provide education that **individual BP readings may vary greatly (high and low) across the monitoring period**

Hypertension. 2019;73:e35–e66

103

Preferred devices and cuffs

- Use an upper-arm cuff oscillometric device that has been validated
- Use a device that is able to automatically store all readings
- Use a device that can print results or can send BP values electronically to the healthcare provider
- Use a cuff that is appropriately sized for the patient's arm circumference

Hypertension. 2019;73:e35–e66

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Best practices for the patient preparation

- Have an empty bladder
- Rest quietly in seated position for at least 5 min
- Do not talk or text
- Position Sit with back supported and both feet flat on the floor
- BP cuff should be placed on a bare arm (not over clothes)

Hypertension. 2019;73:e35–e66

105

Actions to Prepare Care Teams to Support SMBP

- Standardize training of clinicians to take blood pressure readings and teach SMBP techniques to their patients.
- Conduct an initial clinician competency exam for pertinent staff and new employees to demonstrate proper technique in:
  - Cuff selection
  - Patient positioning
  - Measurement without talking
  - Accurate observation of the blood pressure level
  - Consider additional competency training for all employees at regular intervals.

Centers for Disease Control and Prevention. Self-Measured Blood Pressure Monitoring: Actions Steps for Clinicians. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2014.

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Actions to Prepare Care Teams to Support SMBP

- Train relevant **team** members (e.g., PAs, NPs, nurses, pharmacists) to lead the clinical support piece of SMBP interventions.
- Clinical support programs should be delivered only by clinicians specifically trained for the intervention.
- Incorporate this clinical support into existing disease management programs.

Centers for Disease Control and Prevention. Self-Measured Blood Pressure Monitoring: Actions Steps for Clinicians. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2014.

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Actions to Empower Patients to Use SMBP

- Discuss with your patients
- Review the types of available SMBP devices and work with patients to choose the best option.
- Check the home device for accuracy by comparing readings to a reliable office device.
- Train patients on proper SMBP technique. Explain:
  - How to operate the device.
  - Patient preparation.
  - Proper positioning and technique.
  - When to measure BP (time of day/frequency).

Patients should communicate all BP records to a clinician.

Centers for Disease Control and Prevention. Self-Measured Blood Pressure Monitoring: Actions Steps for Clinicians. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2014.

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Home Blood Pressure Monitors

Table 5. Preferred Characteristics of a Home Blood Pressure Monitor[1]

Preferred	Not Preferred
Automated	Manual
Upper-arm cuff	Wrist cuff*
Properly sized cuff	Too-large or too-small cuff
Memory storage capacity	No memory storage
Printing capacity	No printer
Ability to upload BP readings to computer or other electronic device	No ability to upload
Accuracy checked by clinician after purchase	Patient uses monitor without consulting clinician

*Wrist cuffs may be used as an alternative for patients who are obese or have other difficulties using upper-arm cuffs, but the accuracy of readings may be inconsistent.

Centers for Disease Control and Prevention. Self-Measured Blood Pressure Monitoring: Actions Steps for Clinicians. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2014.

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Table 2. Corresponding Values of Clinic, Home, Daytime, Nighttime, and 24-Hour BP Measurements (2017 American College of Cardiology/American Heart Association Guidelines)

Clinic	HBPM	Daytime ABPM	Nighttime ABPM	24-Hour ABPM
120/80	120/80	120/80	100/65	115/75
130/80	130/80	130/80	110/65	125/75
140/90	135/85	135/85	120/70	130/80
160/100	145/90	145/90	140/85	145/90

ABPM indicates ambulatory blood pressure monitoring; BP, blood pressure; and HBPM, home blood pressure monitoring.

Hypertension. 2019;74:229-236

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Conclusions

- Self-Monitored Blood Pressure and Home Blood Pressure Monitoring are critical components of team-based hypertension management.
- The SMBP and HBPM values must be valid and trusted by the Team in order to have impact.

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Q&A

DANIEL T. LACKLAND, DRPH, FACE, FAHA
Medical University of South Carolina

Million Hearts®

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Collaborating with Community Partners to Address Patients Social and Economic Needs

TRICIA RICHARDSON
CEO
SC Thrive

Million Hearts®

113

scThrive

Collaborating to Address SDoH

September 1, 2020

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We Have the Resources

People in Need | Integrated Support | Community Partners | Service Providers

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The Vision: Dedicated Partners for Community Health

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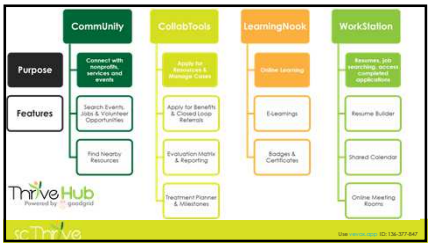

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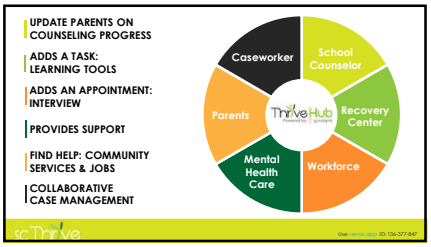

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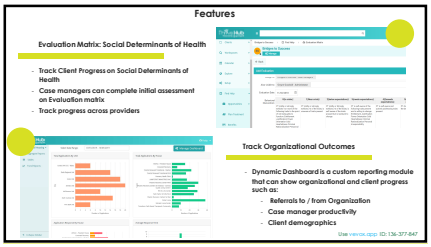

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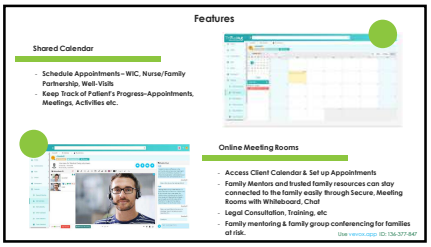

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Sandhills Medical Foundation, Inc

Improving Hypertension Control

Maximizing patient visits to support hypertension management

Crystal A. Maxwell, MD,MBA,FAAFP
Chief Medical Officer

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The Measure

- Hypertension: Blood pressure control <140/90
- DESCRIPTION: % of patients 18 – 85 y/o with hypertension who had blood pressure <140/90 during the measurement period
- IMPROVEMENT NOTATION: Higher score indicates better quality
- INITIAL POPULATION: Patients 18 – 85 y/o with hypertension with a visit during the measurement period
- DENOMINATOR: Equals Initial Population
- NUMERATOR: Patients whose most recent blood pressure <140/90

128

SMF 2011-2014 Data

Health Center	% of patients 18 – 85 y/o with hypertension who had blood pressure <140/90 during the measurement period				
	2011	2012	2013	2014	
Sandhills Medical Foundation, Inc.	51%	48%	55%	64%	

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IMPACT

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Quality Improvement

- 2013 received PCMH accreditation via NCQA
  - 2011-2013 began assessing process and coordinating uniform processes at all sites
- 2013 Quarterly Clinician bonuses initiated
  - 6 quality measures (diabetes, hypertension, breast cancer screening, cervical cancer screening, colon cancer screening, pneumonia vaccination)
  - 2 Additional: Closing out charts and Meeting attendance

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Managing Barriers

- PDSA Cycles completed 2014-2017
- Barriers found:
  - Not taking meds before visits
  - Proper BP measurements
  - Data inaccuracies
  - Variation in follow up among clinicians
  - Medication compliance

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Methods

- Education
  - Reviewed proper blood pressure measurement technique with nursing staff
  - Reviewed proper documentation of repeat bp reading
  - Added blood pressure measurement review to nursing yearly skills check
- Visits
  - Reminded patients to take meds before each visit unless specifically told to fast
  - Nursing staff instructed to repeat bp check if bp >/=140/90
  - Blood pressure log given at visits
  - Care plan with blood pressure goals and medication list given at visits
  - Clinical summary showing changes in medications given at visits

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Methods

- Visits cont.
  - Encouraged Clinicians to schedule nurse blood pressure checks 1-2 weeks after the visit if bp >/=140/90
  - Clinicians cautioned on quantity of refills prescribed if bp uncontrolled
  - Patients instructed to take meds at least 1-2 hours before nurse visit
  - Red flagged message sent to Clinician during nurse visit if bp >/=140/90 for management
    - Clinician may work in patient
    - Clinician may send instructions for med change
    - Clinician instructs next follow up

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Change

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SMF 2015–2019 Data

Health Center	N of patients 18 – 85 y/o with hypertension who had blood pressure <140/90 during the measurement period				
	2015	2016	2017	2018	2019
Sandhills Medical Foundation, Inc.	68%	66%	72%	76%	77%

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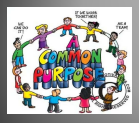
TEAMWORK



"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."
— Maya Angelou

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Best Practice Ideas

- Review and use data
- Utilize PDSA
- Reward those who are doing the work
- Don't over look systolic readings of 140 or diastolic readings of 90
- Integrate methods into workflow
- Utilize nurse visits for closer follow up with Clinician involvement if not at goal
- Caution number of refills provided to those not at goal

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IMPACT

- Integrate
- Methods
- Purposefully
- And
- Change
- Translates

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Questions? Submit on Vevox for Q&A

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Maximizing Patient Visits to Support Hypertension Management

Crystal A. Maxwell
MD, MBA, FAAFP
Chief Medical Officer/Family Physician,
Sandhills Medical Foundation, Inc.

Edward Behling, MD, FAAFP
Chief Medical Officer
Tammy Garris
Clinical Data Integrity Controller
HopeHealth

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Optimizing Patient Visits to Support Hypertension Management

Edward Behling, MD, FAAFP
Tammy Garris, Clinical Data Integrity

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Our Metrics

Measure	2019
Blood Pressure at every Visit	93.7%
Statin Therapy for Prevention & Treatment of CVD	78.9%
Undiagnosed HTN	13.1%
Essential HTN Prevalence	45.1%
HTN Prevalence	51.0%

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Awareness

Staff Education:
- Refresher trainings
- Implement Staff trainings/new education

Program Creation/Enhancements
- Implement programs that focus on identifying causes of increased BP

Patient Education:
- Educate patients on symptom recognition and self-management

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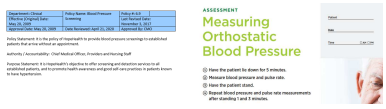
Staff Education

Refresher training on Standing Orders with regards to Hypertension/CVD

Standardization of Measuring Orthostatic BP – CDC Guideline



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Staff Education

Our Director of Pharmacy and Quality Manager created training for Clinical Staff to educate on the many types of anti-hypertensives.

147

Program Creation/Enhancements

Implemented programs that focus on identifying causes of increased BP

Smoking Cessation Program:
- Targets smoking AND vaping
- Provides at-home devices (BP cuff/monitor)
- Specific education

Medication Adherence Program:
- Partner pharmacy contacts patients who fail to pick up prescriptions
- Providers are notified when medications are not picked up repeatedly

Health and Nutrition:
- Offer various cooking and food prep classes
- Educate patients on exercise, stress management and lifestyle coaching
- Provide The HopeHealth Plate Planner in conjunction with ChooseMyPlate.gov

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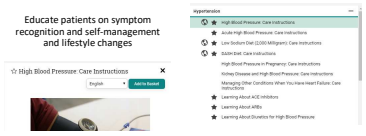
Patient Education

Educate patients on symptom recognition and self-management and lifestyle changes



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Impact of Interventions

Measure	2019	2020
Blood Pressure at every Visit (decreased due to volume of Telehealth visits)	93.7%	84.1%
Statin Therapy for Prevention & Treatment of CVD	78.9%	81.8%
Undiagnosed HTN	13.1%	10.2%
Essential HTN Prevalence	45.1%	51.0%
HTN Prevalence	51.0%	54.6%

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Q&A

Combined

Crystal A. Maxwell MD, MBA, FAAFP
Chief Medical Officer/Family Physician, Sandhills Medical Foundation, Inc.

Edward Behling, MD, FAAFP
Chief Medical Officer

Tammy Garris
Clinical Data Integrity Controller
HopeHealth

Million Hearts®

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Integrating Community Health Workers into Team-based Care

Andrea Heyward, MHS, MCHES
Systems Integration Manager
Center for Community Health Alignment
and the Community Health Worker Institute

Million Hearts®

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CENTER FOR COMMUNITY HEALTH ALIGNMENT

Integrating Community Health Workers into Team-based Care

PRESENTED BY: Andrea Heyward, MHS, MCHES

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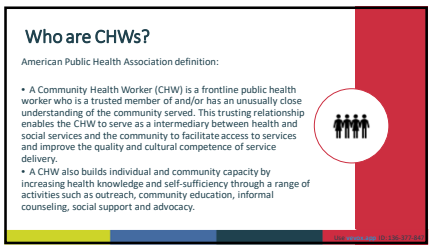

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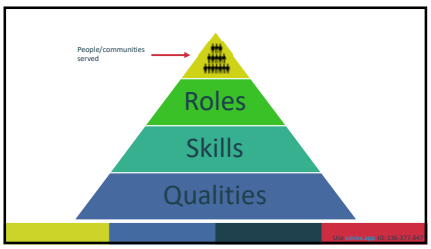

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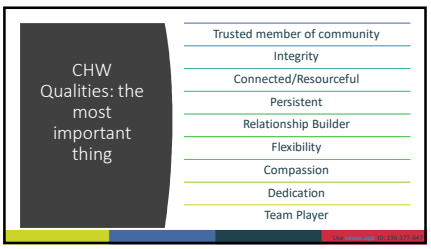

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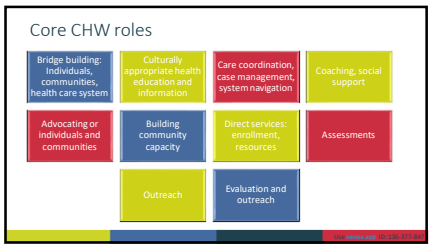

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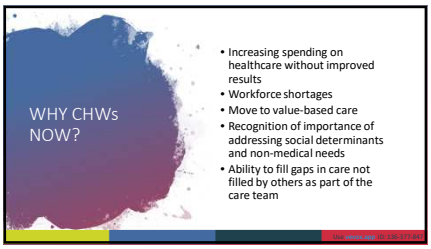

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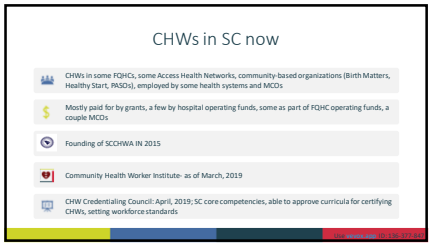

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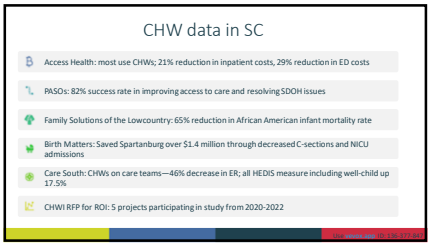

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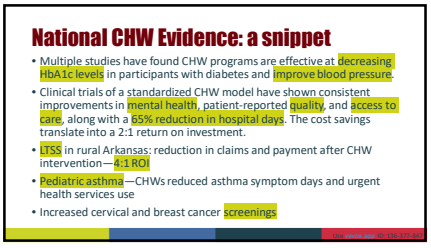

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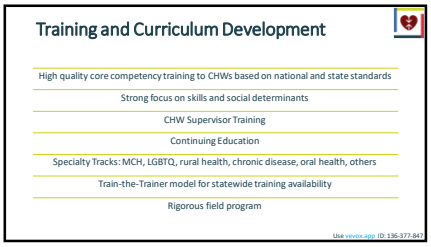

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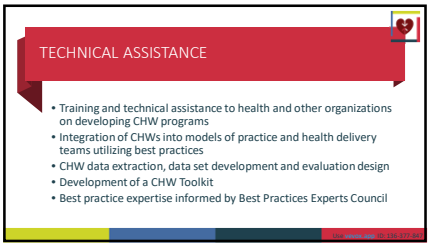

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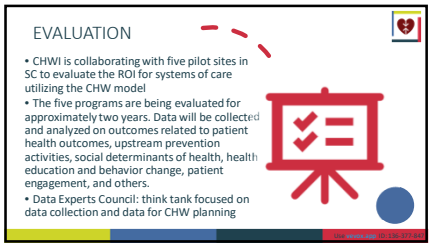

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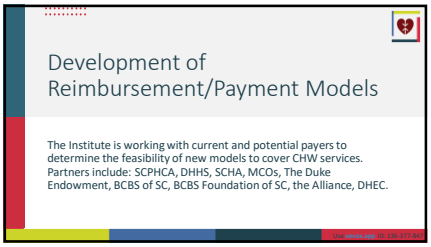

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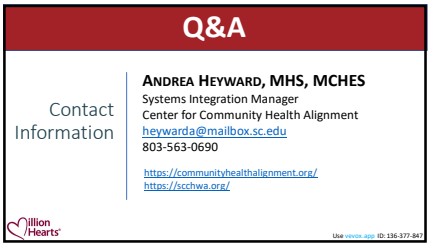

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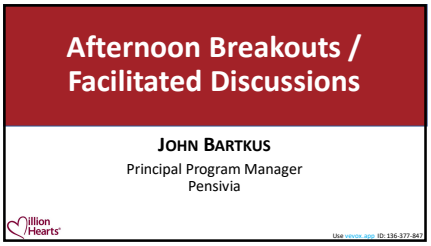

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Breakout Workgroups

Breakout Session Topics	Groups
Increasing Patient Engagement	1A, 1B, 1C
Collaborating with Community Partners	2A, 2B
Maximizing Patient Visits	3A

1:55pm | 2:05pm ET

Breakout Session ~ 75 mins | Report Outs ~ 5 mins each | Common Themes

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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 Discussion (Focused on Five Key Questions) for your Topic:

1. What's **WORKING WELL**? (~15 mins)
2. What are the **KEY CHALLENGES**? (~15 mins)
3. How might we **ADDRESS THESE CHALLENGES**? (~15 mins)
4. What other **OPPORTUNITIES** do we have? (~15 mins)
5. What do we choose to **DO NEXT**? (~10 mins)

Individual Take-aways: (~5 mins)

- What new strategy did I learn today?
- What new partners have I identified today with whom I can work to further my/their goals?
- What are two things I can implement to employ new patient engagement strategies?

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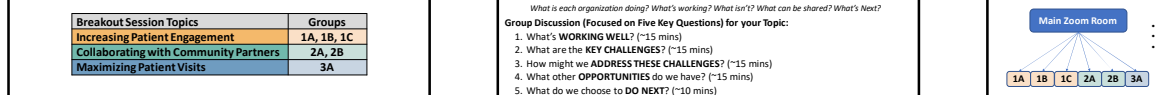
Workgroup Mechanics



- 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)

1:55pm | 2:05pm ET

Breakout Session ~ 75 mins | Report Outs ~ 5 mins each | Common Themes

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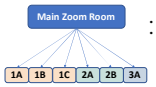
Breakouts In Progress



- 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.

1:55pm | 2:05pm ET

Breakout Session ~ 75 mins | Report Outs ~ 5 mins each | Common Themes

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Group Report Outs

Breakout Session Topics	Groups
Increasing Patient Engagement	1A, 1B, 1C
Collaborating with Community Partners	2A, 2B
Maximizing Patient Visits	3A

Order of Report outs…

1A 2A 1B 2B 1C 3A

Short break now.
Report outs Start at 2:05 pm ET
In

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Common Strategies and Themes

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

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Next Steps

SARAH MILLER COCKRELL
Manager of Clinical Quality Improvement
South Carolina Primary Health Care Association

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Adjourn

JOHN CLYMER

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