# Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in South Dakota

*July 11, 2017*
*Meeting Summary*

**Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in South Dakota**

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Healthy People. Healthy Communities. Healthy South Dakota. That's the vision of the South Dakota Cardiovascular Collaborative, whose members met in Sioux Falls on July 11, 2017, with the American Heart Association to advance the Million Hearts® goal of preventing a million heart attacks and strokes over the next five years. The meeting's objectives: For attendees to arm themselves with ideas to expand their knowledge of evidence-based programs, collaboration strategies, tools, and resources. The group also worked on plans to generate connections to align programs and new initiatives that support Million Hearts.®

The successful meeting included 40 representatives attending on behalf of 24 partner organizations.

The SD Cardiovascular Collaborative separated into working group meetings based on the four goal areas of its strategic plan:

- Improve Data Collection: Explore a process to identify and track cardiovascular indicators available from the health information exchange and other nationally recognized data sources.
- Priority Populations: Promote different models of team-based, patient-centered care, including health cooperative clinic and patient-centered medical homes.
- Continuum of Care: Develop pilot programs for cardiac-ready communities. This team will coordinate and improve continuum for heart disease and stroke.
- Prevention & Management: Encourage the implementation of processes to improve quality in health systems.

The objectives and strategies laid out during the meeting will serve as a blueprint to the South Dakota Cardiovascular Collaborative over the next five years as it works with stakeholders and partners to reduce the burden of heart disease and stroke.

Each of the four goal-area workgroups has planned for regular meetings. In addition, team leads will meet monthly to share progress and exchange lessons learned. Plans for a quarterly newsletter is in the works, along with future meetings for the full Cardiovascular Collaborative: a virtual meeting in November and an in-person gathering in March.


# Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in South Dakota

JULY 11, 2017
9:00 AM - 3:00 PM CT

*Holiday Inn Sioux Falls City Centre*
*100 W 8th St*
*Sioux Falls, South Dakota*

# MEETING PURPOSE:

Connecting staff from AHA Affiliates, state health departments and other state and local heart disease and stroke prevention partners to establish and engage in meaningful relationships around Million Hearts® efforts.

# MEETING OBJECTIVES:

At the end of the meeting, participants will be able to:

1. Identify Million Hearts® focused activities for 2017
2. Recognize Million Hearts® evidence-based and practice-based CVD prevention strategies and approaches
3. List partner programs and resources that align with Million Hearts®
4. Identify programs efforts that align and ways to work together
5. Create plan for follow-up to increase engagement
6. Recognize key contacts within heart disease and stroke prevention

# MEETING OUTCOMES:

Attendees will have expanded their knowledge of evidence based programs, collaboration strategies, tools, resources and connections to align programs and new initiatives that support Million Hearts®.

# AGENDA

9:00 AM **PARTNER NETWORKING**

9:15 AM **WELCOME AND OVERVIEW OF THE DAY**
Julie Harvill, *Operations Manager, Million Hearts® Collaboration*

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

9:20 AM **EXPECTATIONS – APPROACH FOR THE DAY**
John Bartkus, *Principal Program Manager, Pensivia*

Introductions – what excites you about your role in heart disease and stroke prevention? (one sentence)

9:45 AM **MILLION HEARTS® 2022**
Robin Rinker, MPH, CHES, *Health Communications Specialist*
*Division for Heart Disease and Stroke Prevention*
*Centers for Disease Control and Prevention*

- Million Hearts® Accomplishments
- What must happen to prevent?
- 2017 Focus

**Q & A / GROUP INTERACTION**

10:30 AM **BREAK**

10:45 AM **SOUTH DAKOTA DEPARTMENT OF HEALTH INTRODUCES THE SOUTH DAKOTA CARDIOVASCULAR COLLABORATIVE STRATEGIC PLAN 2017-2022 AND THOSE AREAS THAT ALIGN WITH MILLION HEARTS®.**
Kiley Hump, M.S., *Administrator*
*Office of Chronic Disease Prevention and Health Promotion*
*South Dakota Department of Health*

**Q & A / GROUP INTERACTION**

11:00 AM **GREAT PLAINS QUALITY INNOVATION NETWORK**
Holly Arends, *Program Manager*
*South Dakota Foundation for Medical Care*

**Q & A**

11:15 AM **AHA/ASA PROGRAMS AND RESOURCES THAT ALIGN WITH MILLION HEARTS®**

Megan Myers, *Government Relations Director, South Dakota*
*American Heart Association, Midwest Affiliate*

**Q & A**

11:30 AM **CATERED LUNCH**

12:15 PM **AFTERNOON BREAKOUTS/FACILITATED DISCUSSIONS**
John Bartkus

**SOUTH DAKOTA CARDIOVASCULAR COLLABORATIVE STRATEGIC PLAN 2017-2022, PARTNERS, PROGRAMS AND PERSONS THAT ALIGN**

Group 1. Improve data collection

Group 2. Priority populations

Group 3. Continuum of care

Group 4. Prevention & management

2:00 PM **REPORTS FROM BREAKOUTS**
John Bartkus

2:30 PM **PLANS FOR FOLLOW-UP/NEXT INTERACTIONS**
John Bartkus

2:50 PM **EVALUATION AND FEEDBACK PROCESS**
Whitney R. Garney, *WRG Consulting*

2:55 PM **WRAP UP**
April Wallace, *Program Initiatives Manager, Million Hearts® Collaboration*

3:00 PM **ADJOURN**

**ORGANIZATIONAL REGISTRANTS AS OF JULY 30, 2017**

*American Heart Association* ▪ *Avera St. Benedict Health Center* ▪ *Centers for Disease Control and Prevention* ▪ *City of Sioux Falls* ▪ *Community HealthCare Association of the Dakotas* ▪ *Emory Centers for Training and Technical Assistance* ▪ *Great Plains Quality Innovation Network* ▪ *Great Plains Tribal Chairmen's Health Board* ▪ *HealthPOINT* ▪ *Million Hearts Collaboration, AHA* ▪ *National Association of Chronic Disease Directors* ▪ *National Forum for Heart Disease & Stroke Prevention* ▪ *Pensivia* ▪ *Sanford Cardiovascular* ▪ *Sioux Falls Health Department* ▪ *Sisseton-Wahpeton Oyate* ▪ *South Dakota Department of Health* ▪ *South Dakota Health Link* ▪ *South Dakota State Medical Association* ▪ *South Dakota Association of Healthcare Organizations* ▪ *Texas A&M* ▪ *US DHHS OASH Region VIII*

## Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in South Dakota
## Tuesday, July 11, 2017
## Holiday Inn Sioux Falls City Centre

| | | | | |
|---|---|---|---|---|
| 1 | April | Wallace | AHA Million Hearts Initiative | Program Initiatives Manager |
| 2 | Julie | Harvill | AHA Million Hearts Initiative | Operations Manager, Million Hearts Collaboration |
| 3 | Chrissy | Meyer | American Heart Association | Communications Director |
| 4 | Pamela | Miller | American Heart Association | Regional Grassroots Advocacy Director |
| 5 | Megan | Myers | American Heart Association | Government Relations Director |
| 6 | Gary | Myers | American Heart Association | Senior Director |
| 7 | Robin | Rinker | Centers for Disease Control and Prevention | Project Officer |
| 8 | Julie | Charbonneau | City of Sioux Falls | RN EM-QAC |
| 9 | Dan | Friedrich | Dakota State University | Director of CAHIT |
| 10 | Mallory | Stasko | Emory Centers for Training and Technical Assistance | Manager, Health Communication & Planning |
| 11 | Holly | Arends | Great Plains QIN/SDFMC | Program Manager |
| 12 | Terra | Houska | Great Plains Tribal Chairmen's Health Board | Tobacco Control Health Educator |
| 13 | Shannon | Udy | Great Plains Tribal Chairmen's Health Board | PSE Health Educator |
| 14 | Kevin | Atkins | HealthPOINT | Engagement Manager |
| 15 | Leanne | Kopfmann | Huron Clinic | CEO |
| 16 | Julia | Schneider | National Association of Chronic Disease Directors | Consultant, CVH Team |
| 17 | Miriam | Patanian | National Association of Chronic Disease Directors | Lead Consultant for CVH and Health Systems |
| 18 | Mary Jo | Garofoli | National Forum for Heart Disease & Stroke Prevention | Operations Analyst |
| 19 | John | Bartkus | Pensivia | Principal Program Manager |
| 20 | Lynn | Thomas | Sanford Cardiovascular | Director |
| 21 | Eric | Van Dusen | Sanford Health/South Dakota EMS Association | FlightParamedic |
| 22 | Sarah | Niemyer | Sanford Heatlh | Business Development |
| 23 | Stan | Kogan | Sioux Falls Health Department | Health Promotion Specialist |
| 24 | Tamee | Livermont | Sioux Falls Health Department | Public Health Intern |
| 25 | Mary | Michaels | Sioux Falls Health Department | Public Health Prevention Coordinator |
| 26 | Gypsy | Wanna | Sisseton Wahpeton Sioux Tribe | Wellness Coordinator |
| 27 | Audrey | German | Sisseton-Wahpeton Oyate | Program Manager |
| 28 | Kristen | Bunt | South Dakota Association of Healthcare Organizations | Director, Quality Integration |
| 29 | Karen | Cudmore | South Dakota Department of Health | Cancer Programs Director |
| 30 | Katie | Hill | South Dakota Department of Health | Communications Coordinator |
| 31 | Marty | Link | South Dakota Department of Health | Director of EMS and Trauma |
| 32 | Colleen | Winter | South Dakota Department of Health | Division Director |
| 33 | Paula | Gibson | South Dakota Department of Health | Bon Homme Community Health |
| 34 | Kiley | Hump | South Dakota Department of Health | Chronic Disease Director |
| 35 | Ashley | Miller | South Dakota Department of Health | Epidemiologist |
| 36 | Rachel | Sehr | South Dakota Department of Health | Heart Disease and Stroke Prevention Coordinator |
| 37 | Mandi | Atkins | South Dakota Health Link | Implementation Specialist |
| 38 | Stacie | Davis | South Dakota Health Link | Clinitcal Engagement Consultant |
| 39 | Whitney | Garney | Texas A&M | Assistant Professor |
| 40 | Linda | Stopp, MPA | US DHHS OASH Region VIII | Public Health Advisor |

**Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention**
**Partners Working Together in South Dakota**
**July 11, 2017**

# Meeting Summary

Reinforced by the recent development of a state plan, South Dakota has a strong group of dedicated partners who recognize the need to align their work to better meet their ultimate vision: Healthy People. Healthy Communities. Healthy South Dakota. Three major themes emerged during the meeting:

- Power of partnership to address the strategies from the strategic plan
- Interest in continuous quality improvement
- Acknowledgement that data has been collected, and that it has been used. The partners now need to identify where the data exists and use it in the spirit of quality improvement.

**Organizing the work by the four goal areas of the strategic plan**
**South Dakota Cardiovascular Collaborative – Strategic Plan 2017-2021**

- Four main Goal Areas – the Collaborative has prioritized a strategy within each goal area for Year 1 implementation
    - **Improve Data Collection**
        - Explore a process to identify and track cardiovascular indicators available from the health information exchange and other nationally recognized data sources
    - **Priority Populations**
        - Promote the different models of team-based, patient-centered care (health cooperative clinic, health homes, patient-centered medical homes)
    - **Continuum of Care**
        - Develop pilot programs for cardiac ready communities
    - **Prevention & Management**
        - Encourage the implementation of quality improvement processes in health systems

The objectives and strategies listed in this strategic plan were selected by a group of diverse stakeholders. The plan serves as a guide to all stakeholders and partners across the state to work together to reduce the burden of heart disease and stroke in South Dakota. It will be used as a "blueprint" – providing direction, focus and accountability over the next five years.

**Sustaining the Momentum**

The new partners that were invited to the table at this meeting can consider themselves the South Dakota Cardiovascular Collaborative. Next steps include meetings of the four goal area workgroups and a quarterly newsletter that will go out to the full Cardiovascular Collaborative. Team Leads meet monthly to share what workgroups are working on and ask questions of each other. The Leadership Team, which includes Team Leads and other members from various organizations, meets quarterly. There will also be two meetings with the full Cardiovascular Collaborative throughout the year, one virtually around November and one in-person meeting around March.

"It's been great having our national partners here. It could be something we consider for our annual meetings for this group. We want to keep connected with all of you and thank you for sharing your knowledge."- Kiley Hump, Director of Chronic Disease, South Dakota Department of Health

**Goal Area Workplans**

Groups were asked to report out on the following areas:

- Summary of Outcomes
- Key Challenges of the Discussion
- Action Plan
- Alignments Found
- Any "asks" of the full team here?
- Sustainability plan for this group

| **IMPROVE DATA COLLECTION** | | | |
|---|---|---|---|
| Mandi Atkins | Stan Kogan | Leanne Kopfmann | Ashley Miller – lead |
| Dan Friedrich | Mallory Stasko* | Kristen Bunt | |
| Kevin Atkins | *Whitney Garney* | *Robin Rinker* | |
| **Goal:** Drive policy and population outcomes through improved data collection and analysis for heart disease and stroke. | | | |
| **Strategy:** Identify and track data to support at least one heart disease and stroke policy change or recommendation by 2021 | | | |
| **Deliverable -** Create a survey tool to collect information on cardiovascular indicators from clinics across South Dakota. | | | |
| **Action** | | **Who** | **By When** |
| Meet with Goal area 4 to determine what we may want to include in the survey; Consider a question regarding NQF 18 and policies in place for the survey Goal Area 4 is planning. | | Ashley Miller to connect with Katie Hill | August 18 2017 |

| **PRIORITY POPULATIONS** | | | |
|---|---|---|---|
| Terra Houska | Karen Cudmore | *April Wallace* | Kiley Hump - Lead |
| Stacie Davis | *Julia Schneider* | Linda Stopp | |
| Shannon Udy | Colleen Winter | | |
| **Goal:** Address prevention and treatment needs of priority populations in South Dakota for heart disease and stroke. | | | |
| **Strategy:** Promote the different models of team based, patient-centered care (health cooperative clinic, health homes, patient-centered medical home). | | | |
| **Deliverable – Assess Accreditation within facilities** | | | |
| **Action** | | **Who** | **By When** |
| Assess PCMH accreditation | | Goal 2 Workgroup | Done |
| Assess cost for accreditation and/or recognition | | Goal 2 Workgroup | Done |
| Reach out to IHS – how are they implementing team-based care<br>IHS representative on leadership team | | GPTCHB | August 31, 2017 |
| **Deliverable – Research; Gather more information** | | | |
| **Action** | | **Who** | **By When** |
| Identify gaps in the state not implementing PCMH | | Goal 2 Workgroup | Done |
| Connect with Kathy Mueller from DSS Health Homes<br>Connect to larger health plans and payers<br>Develop reference guide of different models | | Kiley Hump/ Stacie Davis<br>Goal 2 Workgroup | September 30, 2017 |
| **Deliverable – Provide education on team-based care models** | | | |
| **Action** | | **Who** | **By When** |
| Identify organizations to offer education on team-based care / patient-centered medical home<br>CHAD training<br>Identify physician champion – reach back out to Dr Schroder | | Kiley Hump/Rachel Sehr<br><br>CHAD representative Shannon Udy | Done<br><br>September 2017<br>September 30, 2017 |

| | | |
|---|---|---|
| Partner with Great Plains Chairman's Tribal Group on monthly webinars<br>Connect with regional HRSA office | Linda Stopp | December 30, 2017 |
| **Deliverable - Funding** | | |
| **Action** | **Who** | **By When** |
| Explore funding support for facilities to implement PCMH | Goal 2 Workgroup | January 31, 2018 |
| Talk with insurance companies on payment models | Kiley Hump | January 31, 2018 |

| **CONTINUUM OF CARE** | | | |
|---|---|---|---|
| Eric<br>Marty<br>Lynn | *Julie Harvill*<br>*Mary Jo Garofoli* | | Megan Myers – lead |
| **Goal:** Coordinate and improve continuum of care for heart disease and stroke. | | | |
| **Strategy:** Develop pilot program for cardiac ready communities | | | |
| **Deliverable -** | | | |
| **Action** | | **Who** | **By When** |
| Spreadsheet comparison of 3 state programs: MN, MT, ND | | Julie, Mary Jo | Aug 15 2017 |
| Invite ND to present on their program (ND roadmap) | | Marty | Aug 30 2017 |
| Define pilot/program goal, strategy, outcomes, plan | | Megan | October 30, 2017 |
| Identify communities / champions | | Eric | Fall / Winter 2017 |
| Process for implementation – guidelines and criteria | | Eric | April 30, 2018 |

| **PREVENTION & MANAGEMENT** | | | |
|---|---|---|---|
| Mary Michaels<br>Pamela Miller<br>Audrey German | Gypsy Wanna<br>Rachel Sehr<br>Paula Gibson | Tamee Livermont<br>Sarah Nifmeyer<br>*Holly Arends* | *Miriam Patanian*<br>Katie Hill - lead |
| **Goal:** Enhance prevention and management of heart disease and stroke | | | |
| **Strategy:** Encourage the implementation of quality improvement processes in health systems | | | |
| **Deliverable – Assessment; health indicator matrix** | | | |
| **Action** | | **Who** | **By When** |
| Develop survey objectives by August 18 call- do other groups want to include questions on their survey<br>Could the Core group add to their responsibilities to align work across the various workgroups?<br>Rachel will contact people from today's meeting to identify the health systems QI contacts (Holly can help with this, as can the primary care association, state medical association to leverage existing lists) | | Groups 1 and 4 on a phone call | August 18 2017 |
| Identify QI leadership group<br>Identify health systems and people within those systems we need to work with.<br>QI Leadership: CHAD, SD Foundation for Medical Care, QIN, HIS Great Plains Area, Great Plains Tribal Group | | Rachel Sehr | October 15 2017 |
| Identify student to help with the survey | | Mary Michaels | September 15 2017 |

| | | |
|---|---|---|
| Develop worksheet / matrix tool to help health systems fill out the survey | MPH Student; Holly has a start to the matrix tool | November 1 2017 |
| Send out survey | DOH | November 15 2017 |
| Survey deadline | DOH | December 15 2017 |
| Survey analysis complete | Group 1 – Ashley Miller | March 1 2018 |

# Meeting Notes

**Meeting Purpose:**
Connecting staff from AHA Affiliates, state health departments and other state and local heart disease and stroke prevention partners to establish and engage in meaningful relationships around Million Hearts® efforts.

**Meeting Objectives:**
At the end of the meeting, participants will be able to:

1) Identify Million Hearts focused activities for 2017
2) Recognize Million Hearts® evidence-based and practice-based CVD prevention strategies and approaches
3) List partner programs and resources that align with Million Hearts
4) Identify program efforts that align and ways to work together
5) Create plan for follow-up to increase engagement
6) Recognize key contacts within heart disease and stroke prevention

**Partners**

American Heart Association
Avera St Benedict
City of Sioux Falls
Community HealthCare Assn of the Dakotas
Great Plains Quality Improvement Network / South Dakota Foundation for Medical Care
Great Plains Tribal Chairmen's Health Board
HealthPOINT
Sanford Cardiovascular
Sanford Health
Sioux Falls Health Department
Sisseton-Wahpeton Oyate
South Dakota Association of Healthcare Organizations
-South Dakota Department of Health
-South Dakota EMS Association
-South Dakota State Medical Association
-US Department of Health and Human Services, Office of the Assistant Secretary for Health Region VIII

**Meeting Outcomes:**
Attendees will have expanded their knowledge of evidence-based programs, collaboration strategies, tools, resources and connections to align programs and new initiatives that support Million Hearts®.

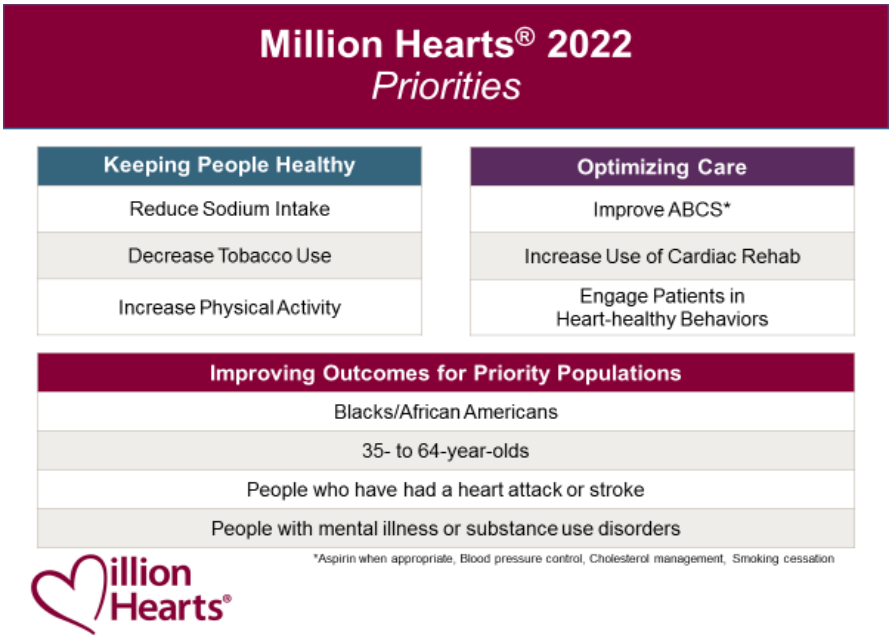
**Million Hearts 2022:**

The goal of Million Hearts is to prevent 1 million heart attacks, strokes, and other cardiovascular events. During the first 5-year phase of Million Hearts®, we made significant progress in many areas. And while final numbers will not be available until 2019, we estimate that up to half a million events may have been prevented from 2012-2016. With new strategies in place, we are hoping to build on our momentum over the next five years.

Million Hearts® 2022 is co-led by the Centers for Disease Control & Prevention and the Centers for Medicare and Medicaid Services. But it is carried out by a variety of partners across federal and state agencies, and private organizations.

Million Hearts® provides a platform to shine light on a selection of evidence-based strategies for cardiovascular disease prevention, and it serves as a learning lab and repository of tools, protocols, and resources for partners to use to implement these strategies.

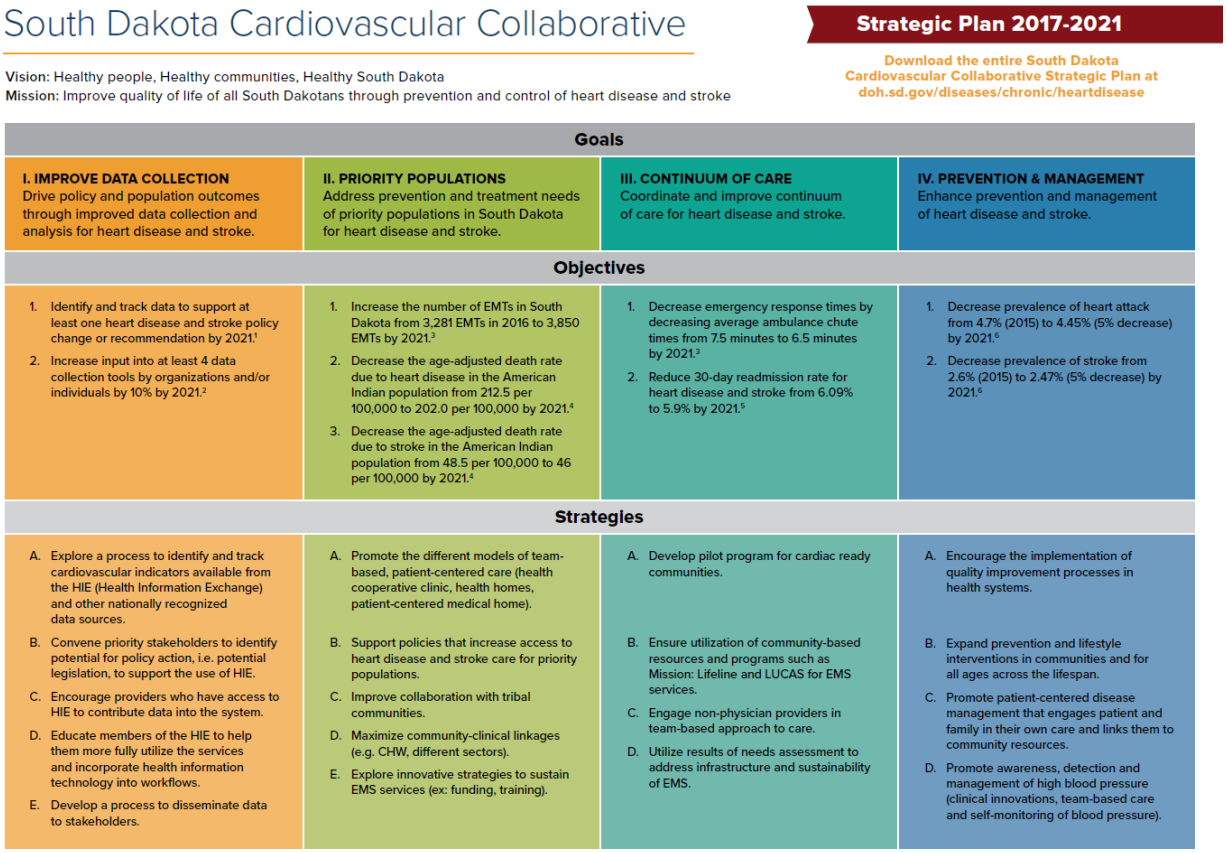
The important thing to note, however, is that while Million Hearts® provides the platform, the strategies, the tools, protocols and resources, it's the partners who are the ones really driving this initiative.



**South Dakota Cardiovascular Collaborative Strategic Plan 2017-2022**

http://doh.sd.gov/documents/diseases/chronic/CardiovascularCollaborativeStrategicPlan_March2017.pdf

The South Dakota Cardiovascular Collaborative Strategic Plan 2017 - 2021 is a collaborative effort of state and local partners working on heart disease and stroke prevention and management in South Dakota. The Cardiovascular Collaborative is a group of about two dozen medical and public health professionals who want to improve the quality of life for all South Dakotans through prevention and control of heart disease and stroke. This group is includes representatives from the South Dakota Department of Health (DOH), American Heart Association, South Dakota Regional Extension Center, South Dakota Health Link, South Dakota State Medical Association and the Community Healthcare Association of the Dakotas.



## South Dakota Cardiovascular Collaborative

**Strategic Plan 2017-2021**

Download the entire South Dakota Cardiovascular Collaborative Strategic Plan at doh.sd.gov/diseases/chronic/heartdisease

**Vision:** Healthy people, Healthy communities, Healthy South Dakota
**Mission:** Improve quality of life of all South Dakotans through prevention and control of heart disease and stroke

| Goals | | | |
|---|---|---|---|
| **I. IMPROVE DATA COLLECTION** Drive policy and population outcomes through improved data collection and analysis for heart disease and stroke. | **II. PRIORITY POPULATIONS** Address prevention and treatment needs of priority populations in South Dakota for heart disease and stroke. | **III. CONTINUUM OF CARE** Coordinate and improve continuum of care for heart disease and stroke. | **IV. PREVENTION & MANAGEMENT** Enhance prevention and management of heart disease and stroke. |
| **Objectives** | | | |
| 1. Identify and track data to support at least one heart disease and stroke policy change or recommendation by 2021.[1]<br>2. Increase input into at least 4 data collection tools by organizations and/or individuals by 10% by 2021.[2] | 1. Increase the number of EMTs in South Dakota from 3,281 EMTs in 2016 to 3,850 EMTs by 2021.[3]<br>2. Decrease the age-adjusted death rate due to heart disease in the American Indian population from 212.5 per 100,000 to 202.0 per 100,000 by 2021.[4]<br>3. Decrease the age-adjusted death rate due to stroke in the American Indian population from 48.5 per 100,000 to 46 per 100,000 by 2021.[4] | 1. Decrease emergency response times by decreasing average ambulance chute times from 7.5 minutes to 6.5 minutes by 2021.[3]<br>2. Reduce 30-day readmission rate for heart disease and stroke from 6.09% to 5.9% by 2021.[5] | 1. Decrease prevalence of heart attack from 4.7% (2015) to 4.45% (5% decrease) by 2021.[6]<br>2. Decrease prevalence of stroke from 2.6% (2015) to 2.47% (5% decrease) by 2021.[6] |
| **Strategies** | | | |
| A. Explore a process to identify and track cardiovascular indicators available from the HIE (Health Information Exchange) and other nationally recognized data sources.<br>B. Convene priority stakeholders to identify potential for policy action, i.e. potential legislation, to support the use of HIE.<br>C. Encourage providers who have access to HIE to contribute data into the system.<br>D. Educate members of the HIE to help them more fully utilize the services and incorporate health information technology into workflows.<br>E. Develop a process to disseminate data to stakeholders. | A. Promote the different models of team-based, patient-centered care (health cooperative clinic, health homes, patient-centered medical home).<br>B. Support policies that increase access to heart disease and stroke care for priority populations.<br>C. Improve collaboration with tribal communities.<br>D. Maximize community-clinical linkages (e.g. CHW, different sectors).<br>E. Explore innovative strategies to sustain EMS services (ex: funding, training). | A. Develop pilot program for cardiac ready communities.<br>B. Ensure utilization of community-based resources and programs such as Mission: Lifeline and LUCAS for EMS services.<br>C. Engage non-physician providers in team-based approach to care.<br>D. Utilize results of needs assessment to address infrastructure and sustainability of EMS. | A. Encourage the implementation of quality improvement processes in health systems.<br>B. Expand prevention and lifestyle interventions in communities and for all ages across the lifespan.<br>C. Promote patient-centered disease management that engages patient and family in their own care and links them to community resources.<br>D. Promote awareness, detection and management of high blood pressure (clinical innovations, team-based care and self-monitoring of blood pressure). |

**South Dakota Foundation for Medical Care, Great Plains, Quality Innovation Network**

Their work with clinics has really opened doors once they started data driven quality improvement.

Foundation Principles: Enable innovation; foster learning organizations such as webinars; eliminate disparities; strengthen infrastructure and data systems- very far along with EMR adoption. Aligned with Million Hearts. Focus on ABCS- feedback reports on national benchmarks. If they are not meeting the mark on a measure, they do quality improvements with the clinics to improve it.

Their approach:

- Offering technical assistance on the Physician Quality Reporting System (PQRS) cardiovascular measures submission for participating clinics
- Assist home health agencies with measures reporting through the Home Health Cardiovascular Data Registry
- Help clinics utilize EHRs for data analysis and performance improvement activities focused on clinical quality measures

We need health home representatives at the table- they have some fabulous resources/modules. South Dakota Performance- improved significantly over the years. They have seen some increases on PQRS, HEDIS measures. Million Hearts has been a great source of data that they can access.

Question to the group- do you have standardized QI in your organization? Is it centralized or decentralized in various departments?

**AHA/ASA programs and resources that align with Million Hearts**

See 2017 Policy Agenda – This is modified every year based on the latest data and impact on population health.

*Advocacy Priorities: Health Insurance Coverage; Systems of Care: Healthy Living; Tobacco Free.*

Recent Win! CPR in schools was just passed and became law on July 1, 2017. South Dakota was 36th state to require hands-only CPR in required curriculum before graduation. Could train up to 10,000 students a year in bystander CPR. EMS Association will be doing the training.

Cardiac Ready Communities- Program designed to prepare communities to respond and assist to increase survival from a cardiac event occurring outside of the hospital setting. South Dakota is gathering best practices from other states with similar programs.

Tobacco- Free: Last tobacco tax in 2006. Defending smoke free law which passed in 2010.

Hypertension strategies- Increase and sustain blood pressure control; increase percent of hypertensive patients that are self-monitories.

Target BP- Helps practitioners to improve hypertension rates; recognition approach. Health systems/practitioners can sign up to be part of the campaign and they will receive resources to help them implement programs; AHA is available for technical support. http://targetbp.org/

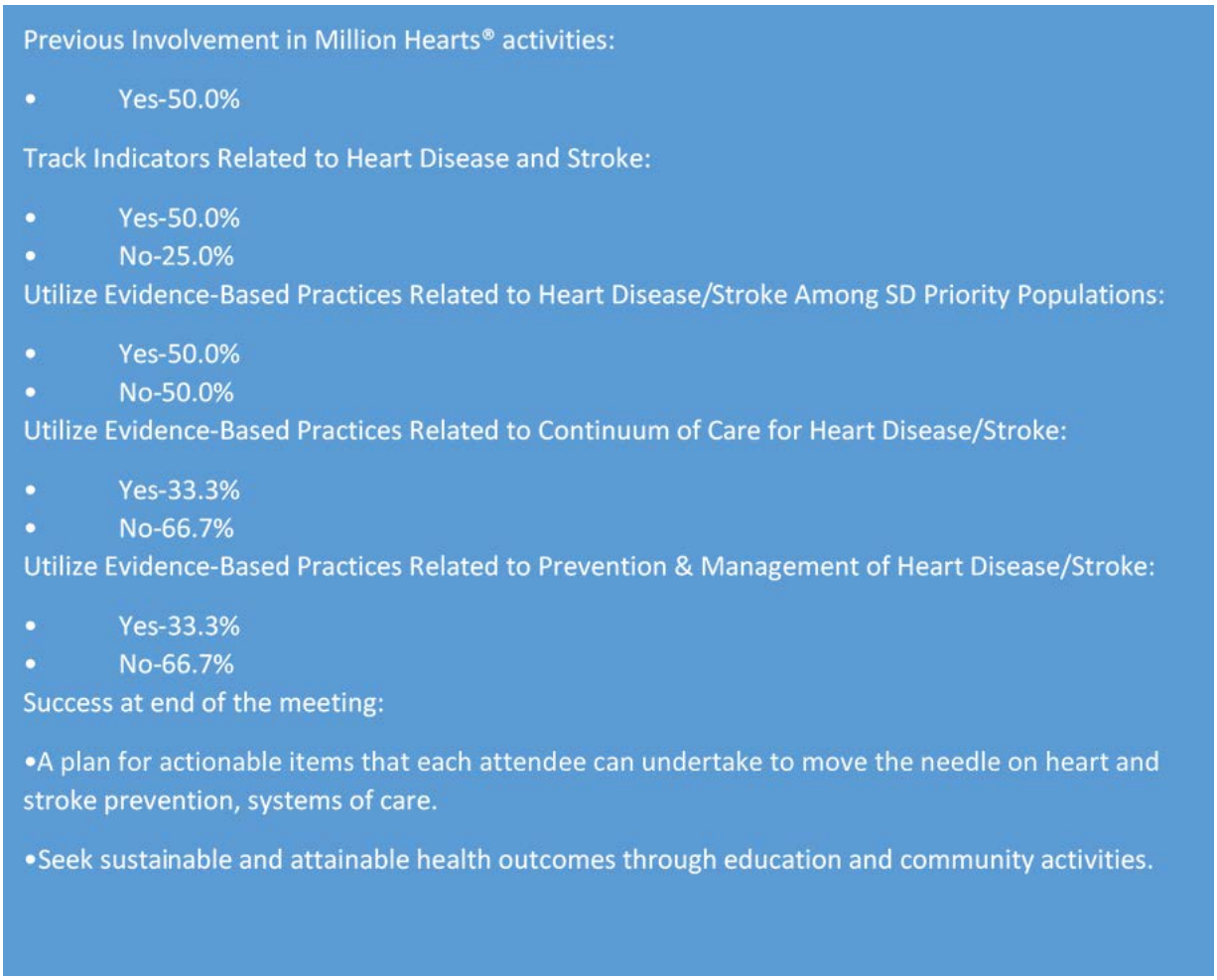
Check.Change.Control CHOLESTEROL- focused on clinicians to adhere to increase adoption and use of cholesterol management guidelines through professional education and quality improvement programs; increase understanding of

and adherence to evidence-based treatment guidelines through public and patient education. AHA is performing market research to identify resources that are helpful to physicians and to identify information that will be most useful for consumers. http://www.heart.org/HEARTORG/Conditions/Cholesterol/Check-Change-Control-Cholesterol-Program_UCM_491936_SubHomePage.jsp

For more information visit: http://www.heart.org/HEARTORG/Advocate/American-Heart-Association-Million-Hearts_UCM_463392_Article.jsp#.WWT-1YWcE2w

# Supporting Documentation

## Pre-Meeting Survey for Breakout Sessions




## Meeting Agenda:

| Time | Agenda Item/Topic | Speaker/Facilitator |
|---|---|---|
| 9:00 – 9:15 am | **Partner Networking** | |
| 9:15 – 9:20 am | **Welcome** | **Julie Harvill**<br>Operations Manager<br>Million Hearts® Collaboration |
| 9:20 - 9:40am | **Expectation – Approach for the Day**<br><br>Introductions – what excites you about your role in heart disease and stroke prevention? (one sentence) | **John Bartkus**<br>Principle Program Manager<br>Pensivia |

| | | |
|---|---|---|
| 9:40 – 10:30am | **Million Hearts® 2022**<br>• Million Hearts® Accomplishments<br>• What must happen to prevent?<br>• 2017 Focus<br><br>Q and A/Group Interaction | **Robin Rinker, MPH, CHES**<br>Health Communications Specialist<br>Division for Heart Disease and Stroke Prevention<br>Centers for Disease Control and Prevention |
| 10:30 – 10:45am | **Break** | |
| 10:45 – 11:00am | **South Dakota Department of Health introduces the South Dakota Cardiovascular Collaborative Strategic Plan 2017-2022 and those areas that align with Million Hearts®.**<br><br>Q and A/Group Interaction | **Kiley Hump, M.S.**<br>Administrator<br>Office of Chronic Disease Prevention and Health Promotion<br>South Dakota Department of Health |
| 11:00 – 11:15am | **South Dakota Foundation for Medical Care, Great Plains, Quality Innovation Network**<br><br>Q and A | **Nancy Beaumont**<br>Director of Quality Improvement<br>South Dakota Foundation for Medical Care<br>Great Plains<br>Quality Innovation Network |
| 11:15 – 11:30am | **AHA/ASA programs and resources that align with Million Hearts**<br><br>Q and A | **Megan Myers**<br>Government Relations Director, South Dakota<br>American Heart Association, Midwest Affiliate |
| 11:30 am – 12:15 pm | **Lunch** | |
| 12:15 – 3:00pm | **Afternoon Breakouts/Facilitated Discussions** | **John Bartkus** |
| | **South Dakota Cardiovascular Collaborative Strategic Plan 2017-2022, Partners, Programs and Persons that Align**<br><br>**Group I. IMPROVE DATA COLLECTION**<br>Drive policy and population outcomes through improved data collection and analysis for heart disease and stroke.<br>A. Identify and track data to support at least one heart disease and stroke policy change or recommendation by 2021.1<br><br>**Group II. PRIORITY POPULATIONS**<br>Address prevention and treatment needs of priority populations in South Dakota for heart disease and stroke<br>A. Promote the different models of team based, patient-centered care (health cooperative clinic, health homes, patient-centered medical home).<br><br>**Group III. CONTINUUM OF CARE**<br>Coordinate and improve continuum of care for heart disease and stroke.<br>A. Develop pilot program for cardiac ready communities.<br><br>**Group IV. PREVENTION & MANAGEMENT** | |

| | | |
|---|---|---|
| | Enhance prevention and management of heart disease and stroke.<br>A. Encourage the implementation of quality improvement processes in health systems. | |
| 2:00 – 2:30pm | **Reports from Breakouts** | |
| 2:30 – 2:45p.m | **Plans for follow-up/next interactions** | |
| 2:50 – 2:55p.m | **Evaluation and Feedback Process** | **Whitney R. Garney**<br>WRG Consulting |
| 2:55 p.m. | **Wrap Up** | **April Wallace**<br>Program Initiatives Manager<br>Million Hearts® Collaboration |
| 3:00 p.m. | **Adjourn** | |

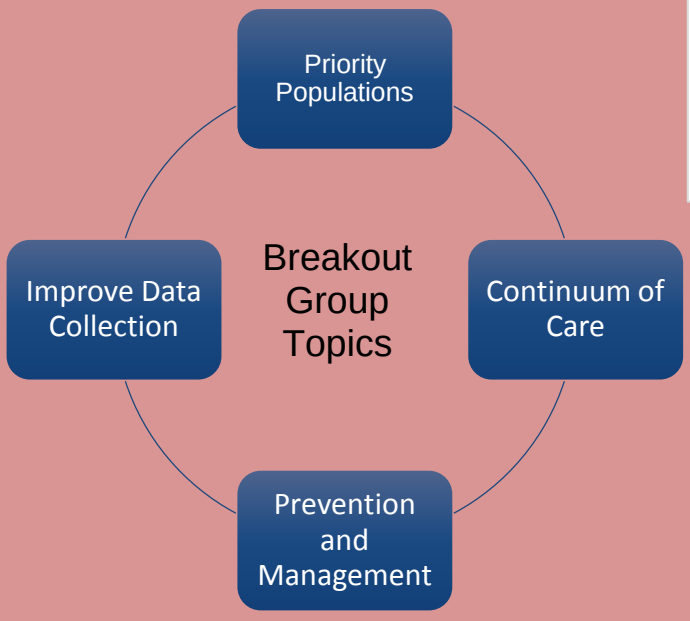
# Advancing Million Hearts ®:
# American Heart Association and Heart Disease and Stroke Prevention Partners Working Together in South Dakota

*July 11, 2017*

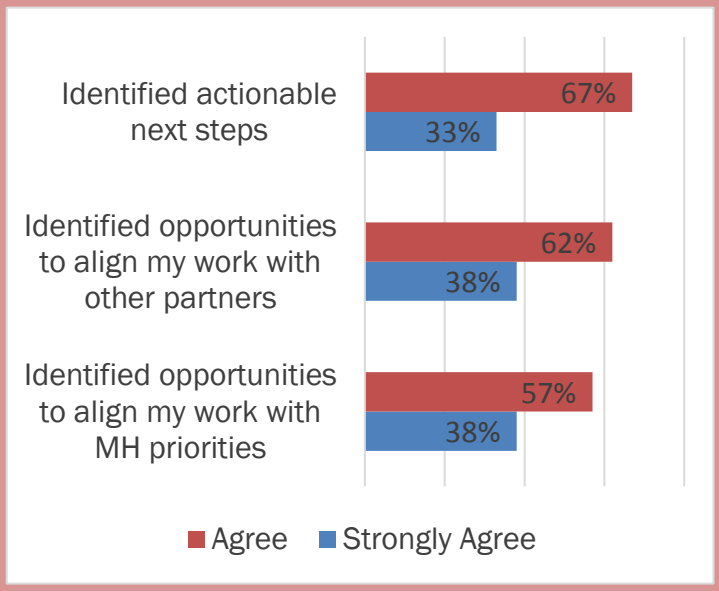
*On July 11, 2017, the American Heart Association (AHA) worked with partners to host the Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in South Dakota Meeting. The goal of the meeting was for attendees to expand their knowledge of evidence-based programs, collaboration strategies, tools, resources and generate connections to align programs and new initiatives that support Million Hearts® (MH).*

**40 South Dakota partners attended the meeting representing 24 organizations.**

**Participants attended breakout groups to plan activities and establish action plans.**




**Participants felt the meeting allowed them to:**




*I have a "better understanding of Million Hearts and its efforts...never really had a full understanding of its scope"*

*-Meeting Participant*

***Participants felt the most valuable part of the meeting was…***

Meeting Variety New Partners Million Hearts Networking Efforts

# South Dakota Cardiovascular Collaborative

**Strategic Plan 2017-2021**

**Vision:** Healthy people, Healthy communities, Healthy South Dakota
**Mission:** Improve quality of life of all South Dakotans through prevention and control of heart disease and stroke

**Download the entire South Dakota Cardiovascular Collaborative Strategic Plan at doh.sd.gov/diseases/chronic/heartdisease**

## Goals

### I. IMPROVE DATA COLLECTION
Drive policy and population outcomes through improved data collection and analysis for heart disease and stroke.

### II. PRIORITY POPULATIONS
Address prevention and treatment needs of priority populations in South Dakota for heart disease and stroke.

### III. CONTINUUM OF CARE
Coordinate and improve continuum of care for heart disease and stroke.

### IV. PREVENTION & MANAGEMENT
Enhance prevention and management of heart disease and stroke.

## Objectives

1. Identify and track data to support at least one heart disease and stroke policy change or recommendation by 2021.[1]
2. Increase input into at least 4 data collection tools by organizations and/or individuals by 10% by 2021.[2]

1. Increase the number of EMTs in South Dakota from 3,281 EMTs in 2016 to 3,850 EMTs by 2021.[3]
2. Decrease the age-adjusted death rate due to heart disease in the American Indian population from 212.5 per 100,000 to 202.0 per 100,000 by 2021.[4]
3. Decrease the age-adjusted death rate due to stroke in the American Indian population from 48.5 per 100,000 to 46 per 100,000 by 2021.[4]

1. Decrease emergency response times by decreasing average ambulance chute times from 7.5 minutes to 6.5 minutes by 2021.[3]
2. Reduce 30-day readmission rate for heart disease and stroke from 6.09% to 5.9% by 2021.[5]

1. Decrease prevalence of heart attack from 4.7% (2015) to 4.45% (5% decrease) by 2021.[6]
2. Decrease prevalence of stroke from 2.6% (2015) to 2.47% (5% decrease) by 2021.[6]

## Strategies

A. Explore a process to identify and track cardiovascular indicators available from the HIE (Health Information Exchange) and other nationally recognized data sources.
B. Convene priority stakeholders to identify potential for policy action, i.e. potential legislation, to support the use of HIE.
C. Encourage providers who have access to HIE to contribute data into the system.
D. Educate members of the HIE to help them more fully utilize the services and incorporate health information technology into workflows.
E. Develop a process to disseminate data to stakeholders.

A. Promote the different models of team-based, patient-centered care (health cooperative clinic, health homes, patient-centered medical home).
B. Support policies that increase access to heart disease and stroke care for priority populations.
C. Improve collaboration with tribal communities.
D. Maximize community-clinical linkages (e.g. CHW, different sectors).
E. Explore innovative strategies to sustain EMS services (ex: funding, training).

A. Develop pilot program for cardiac ready communities.
B. Ensure utilization of community-based resources and programs such as Mission: Lifeline and LUCAS for EMS services.
C. Engage non-physician providers in team-based approach to care.
D. Utilize results of needs assessment to address infrastructure and sustainability of EMS.

A. Encourage the implementation of quality improvement processes in health systems.
B. Expand prevention and lifestyle interventions in communities and for all ages across the lifespan.
C. Promote patient-centered disease management that engages patient and family in their own care and links them to community resources.
D. Promote awareness, detection and management of high blood pressure (clinical innovations, team-based care and self-monitoring of blood pressure).

Sources: 1) TBD; 2) Data from healthcare facilities; 3) DOH EMT database; 4) Vital Statistics, 2015; 5) QIN Report, Sept 2016; 6) BRFSS, 2015 | March 2017

Note on Goal 3: Chute time is a measurement of time from the notification of the crew until the ambulance begins moving toward the emergency scene. A current analysis of EMS chute times showed an average of 7.5 minutes for a 911 response. EMS directors from 130 ground and air licensed ambulance services in SD were surveyed in the summer of 2016. Out of the 130 services, 76% reported they track and measure chute times while 24% report they did not. To effectively increase awareness of and reduce chute times by 2021, the EMS Program will focus strategies on increasing the awareness of monitoring chute times locally. Of course, many other contributing factors pay a role in increased chute times, volunteerism plays the most significant factor.

# Million Hearts® Resources

Resources for Clinicians:

- **Hypertension Control: Change Package for Clinicians**
  *http://millionhearts.hhs.gov/files/HTN_Change_Package.pdf*
  A quality improvement change package with a listing of process improvements that ambulatory clinical settings can implement as they seek optimal hypertension control.

- **Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians**
  *http://millionhearts.hhs.gov/files/MH_SMBP_Clinicians.pdf*
  A guide to facilitate the implementation of self-measured blood pressure monitoring (SMBP) plus clinical support in preparing care teams to support SMBP, selecting and incorporating clinical support systems, empowering patients, and encouraging health insurance coverage for SMBP plus additional clinical support.

- **Evidence-Based Hypertension Treatment Protocols**
  *http://millionhearts.hhs.gov/tools-protocols/protocols.html*
  A webpage with a hypertension treatment protocol template and featured evidence-based protocols to help clinicians improve blood pressure control by clarifying titration intervals, revealing new treatment options and expanding the types of staff that can assist in a timely follow-up with patients.

- **Tobacco Cessation Protocol**
  A webpage with a tobacco cessation protocol template and featured evidence-based protocols to help clinicians identify patients who use tobacco and systematically deliver appropriate cessation services.
  http://millionhearts.hhs.gov/tools-protocols/protocols.html#TCP

- **Undiagnosed Hypertension**
  *http://millionhearts.hhs.gov/tools-protocols/hiding-plain-sight/index.html*
  A webpage that describes the phenomena of patients with uncontrolled hypertension being seen by clinicians, but remaining undiagnosed; resources, references and case studies are provided to help clinicians find their undiagnosed hypertensive patients.
    - **Hypertension Prevalence Estimator**
      *https://nccd.cdc.gov/MillionHearts/Estimator/*
      An interactive tool health systems and practices can use to start or build on their existing hypertension management quality improvement process by comparing the expected hypertension prevalence generated from the tool with their calculated prevalence.

- **Million Hearts® Clinical Quality Measures (CQM)**
  *http://millionhearts.hhs.gov/data-reports/cqm.html*
  A webpage that displays national clinical quality measures and targets focused on the Million Hearts® ABCS (Aspirin when appropriate, Blood pressure control, Cholesterol management, and Smoking cessation).

- **Medication Adherence Resources**
  https://millionhearts.hhs.gov/tools-protocols/medication-adherence.html
  A webpage with a variety of resources, tools, tip sheets and success stories to help patients take medications correctly and consistently.

- **Health IT Resources:**
  https://millionhearts.hhs.gov/tools-protocols/tools/health-IT.html
  A webpage with health IT resources and tools that enable easier clinical quality reporting and improvement.

Clinically-focused Programs:

- **Million Hearts® Hypertension Control Challenge**
  *http://millionhearts.hhs.gov/partners-progress/champions/index.html*

- **Million Hearts® Cardiovascular Disease Risk Reduction Model**
  *https://innovation.cms.gov/initiatives/Million-Hearts-CVDRRM/*

- **EvidenceNOW: Advancing Heart Health in Primary Care**
  *http://www.ahrq.gov/professionals/systems/primary-care/evidencenow.html*

Public Health Resources and Programs:

- **Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners**
  *http://millionhearts.hhs.gov/files/MH_SMBP.pdf*

- **CDC State Heart Disease and Stroke Prevention Programs**
  *http://www.cdc.gov/dhdsp/programs/index.htm*

Tools for Patients:

- **Heart Age Predictor**
  *http://www.cdc.gov/vitalsigns/cardiovasculardisease/heartage.html*

- **Blood Pressure Wallet Card**
  *http://millionhearts.hhs.gov/files/BP_Wallet_Card.pdf*

- **Smoke Free (SF)**
  *http://smokefree.gov/*

- **Million Hearts® Videos: Personal Stories**
  *http://millionhearts.hhs.gov/news-media/media/videos.html#ps*

Community Engagement:

- **Million Hearts® 2022 Partner Materials**
  https://millionhearts.hhs.gov/about-million-hearts/partner-materials.html

- **Cardiovascular Health: Action Steps for Employers**
  *http://millionhearts.hhs.gov/files/MH_Employer_Action_Guide.pdf*

Supportive Campaigns:

- **Mind Your Risks**
  *https://mindyourrisks.nih.gov/index.html*

- **Tips from Former Smokers**
  *http://www.cdc.gov/tobacco/campaign/tips/index.html*

# Preventing 1 Million Heart Attacks and Strokes by 2022

**Robin Rinker, MPH**
**Health Communications Specialist**
**Division for Heart Disease and Stroke Prevention**
**Centers for Disease Control and Prevention**

## Million Hearts® 2022

- **Aim:** Prevent 1 million—or more—heart attacks and strokes in the next 5 years
- National initiative co-led by:
  - Centers for Disease Control and Prevention (CDC)
  - Centers for Medicare & Medicaid Services (CMS)
- Partners across federal and state agencies and private organizations

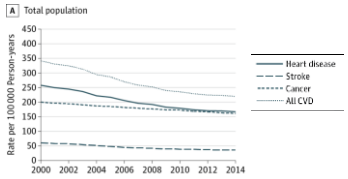
## Heart Disease and Stroke in the U.S.

- More than **1.5 million** people in the U.S. suffer from heart attacks and strokes per year[1]
- More than **800,000** deaths per year from cardiovascular disease (CVD)[1]
- CVD costs the U.S. **hundreds of billions** of dollars per year[1]
- CVD is the greatest contributor to racial disparities in life expectancy[2]

References
1. Benjamin EJ, Blaha MJ, Chiuve SE, Cushman M, Das SR, Deo R, et al. Heart Disease and Stroke Statistics-2017 Update: A Report From the American Heart Association. Circulation 2017;135(10):e146–603.
2. Kochanek KD, Arias E, Anderson RN. How did cause of death contribute to racial differences in life expectancy in the United States in 2010? NCHS data brief, no 125. Hyattsville, MD: National Center for Health Statistics. 2013

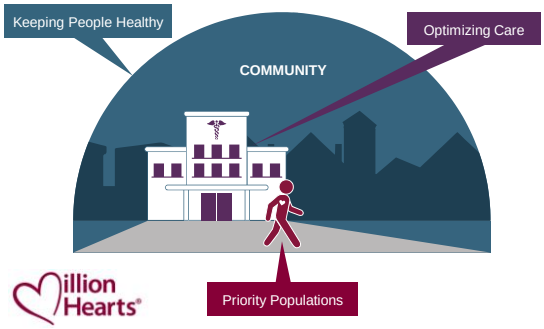
## Heart Disease and Stroke Trend

While CV deaths have been declining for the past 40 years, the **reduction in these deaths has slowed**.




Sidney S, Quesenberry CP, Jaffe MG, Sorel M, Nguyen-Huynh MN, Kushi LH, et al. Recent trends in cardiovascular mortality in the United States and public health goals. *JAMA Cardiol* 2016;1(5):594–9

## Million Hearts® 2022 Aim: *Prevent 1 Million Heart Attacks and Strokes in Five Years*




## 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 illness or substance use disorders |

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

## Keeping People Healthy

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

## Optimizing Care

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

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

## Improving Outcomes for Priority Populations

| Priority Populations | Major Strategies |
|---|---|
| **Blacks/African Americans** | Improving hypertension control |
| **35- to 64-year-olds, because event rates are rising** | • Improving hypertension control and statin use<br>• Increasing physical activity |
| **People who have had a heart attack or stroke** | • Increasing cardiac rehab referral and participation<br>• Avoiding exposure to particulate matter |
| **People with mental illness or substance use disorders** | Reducing tobacco use |

## Million Hearts® Resources and Tools

- **Action Guides**—Hypertension control; Self-measured blood pressure monitoring (SMBP); Tobacco cessation; Medication adherence
- **Protocols**—Hypertension treatment; Tobacco cessation; Cholesterol management
- **Tools**—Hypertension prevalence estimator; ASCVD risk estimator
- **Health IT**
- **Clinical Quality Measures**
- **Consumer Resources and Tools**

## Partner Opportunities: Hospitals *Sample Actions to Consider*

- **Action:** Make healthy food and beverage choices available to patients, visitors, and staff
  - **Resource:** HHS/GSA Health and Sustainability Guidelines for Federal Concessions and Vending Operations
  - **Success Story:** Sodium Reduction Community Program Los Angeles County Department of Public Health
- **Action:** Implement comprehensive smoke-free policies
  - **Resource:** The Community Guide: Tobacco Use and Secondhand Smoke Exposure: Smoke-Free Policies
  - **Success Story:** Communities Putting Prevention to Work: Tobacco Use Prevention and Control
- **Action:** Institute automatic referral of eligible patients to cardiac rehab
  - **Resource:** Increasing Cardiac Rehabilitation Participation From 20% to 70%: A Road Map From the Million Hearts Cardiac Rehabilitation Collaborative

## Partner Opportunities: Employers *Sample Actions to Consider*

- **Action:** Make healthy food and beverage choices available to all employees
  - **Resource:** HHS/GSA Health and Sustainability Guidelines for Federal Concessions and Vending Operations
  - **Success Story:** Sodium Reduction Community Program Los Angeles County Department of Public Health
- **Action:** Develop and support policies at worksites to encourage use of tobacco cessation services.
  - **Resource:** The Community Guide: Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions
  - **Success Story:** North Carolina Division of Public Health, Tobacco Prevention and Control Branch: Expanding Comprehensive Coverage for Tobacco Cessation
- **Action:** Provide environmental supports for recreation or physical activity (e.g., onsite exercise facility, walking trails, bicycle racks).
  - **Resource:** CDC Worksite Health ScoreCard
  - **Success Story:** Bike Share Program Offers California State Employees Another Way to Be Active

## Partner Opportunities: Clinical Care Teams
*Sample Actions to Consider*

- **Action:** Use standardized treatment protocols for hypertension treatment, tobacco cessation, and cholesterol management
  - **Resource:** CDC: Million Hearts® Protocols
  - **Success Story:** 2014 Hypertension Control Champions: Large Health Systems
- **Action:** Implement self-measured blood pressure monitoring (SMBP) interventions with clinical support
  - **Resource:** Million Hearts® Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians
  - **Success Stories:** 2013 Hypertension Control Champion: Nilesh V. Patel, MD; 2015 Hypertension Control Champion: Reliant Medical Group
- **Action:** Improve performance on Million Hearts® clinical quality measures on aspirin, BP control, cholesterol, smoking cessation, and cardiac rehab
  - **Resource:** Million Hearts® ABCS measures
  - **Success Story:** Association of State and Territorial Health Officials (ASTHO) Million Hearts Minnesota
- **Action:** Leverage electronic health record (EHR) systems to excel in the ABCS
  - **Resource:** Million Hearts® EHR Optimization Guides
  - **Success Story:** Michigan Center for Effective IT Adoption

## Stay Connected

- Million Hearts® eUpdate Newsletter
- Million Hearts® on Facebook and Twitter
- Million Hearts® Website
- Million Hearts® for Clinicians Microsite


## Million Hearts® for Clinicians Microsite

- Features Million Hearts® protocols, action guides, and other QI tools
- Syndicates **LIVE** Million Hearts® on your website for your clinical audience
- Requires a small amount of HTML code—customizable by color and responsive to layouts and screen sizes
- Content is free, cleared, and continuously maintained by CDC

Available at https://tools.cdc.gov/medialibrary/index.aspx#/microsite/id/279017

# Million Hearts® 2022

## Preventing 1 Million Heart Attacks and Strokes by 2022

**Every 40 seconds, an adult dies from a heart attack, stroke, or other adverse outcomes of cardiovascular disease (CVD)**. These deaths account for about one third (30.9%) of all deaths in the United States, or more than 800,000 deaths each year. About 1 in 5 of these deaths is a person younger than 65. Heart disease and stroke can also lead to other serious illnesses, disabilities, and lower quality of life.

The economic toll of CVD is high—more than $316 billion each year in the United States—with CVD treatment accounting for about $1 of every $7 spent on health care in this country.

While cardiovascular deaths have been declining for the past 40 years, the reduction in these deaths has slowed since 2011, indicating the need for focused, sustained action by public and private partners to improve our nation's cardiovascular health.

## Million Hearts® 2022

Million Hearts® 2022 is a national initiative co-led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services to prevent 1 million heart attacks and strokes in 5 years. The initiative focuses partner actions on a small set of priorities selected for their impact on heart disease, stroke, and related conditions.

## Million Hearts® 2022 Goals

Reaching these goals will result in 1 million fewer heart attacks and strokes in the next 5 years:

- 20% reduction in sodium intake
- 20% reduction in tobacco use
- 20% reduction in physical inactivity
- 80% performance on the ABCS Clinical Quality Measures
- 70% participation in cardiac rehab among eligible patients

Million Hearts®
millionhearts.hhs.gov

## Stay Connected

Learn more about Million Hearts® and how you can join this national effort and take action to prevent 1 million heart attacks and strokes by 2022.

- Visit **millionhearts.hhs.gov**.
- Connect with **Million Hearts®** on Facebook.
- Follow **@MillionHeartsUS** on Twitter.
- Sign up for the Million Hearts® e-Update at **millionhearts.hhs.gov/news-media**.

## What You Can Do

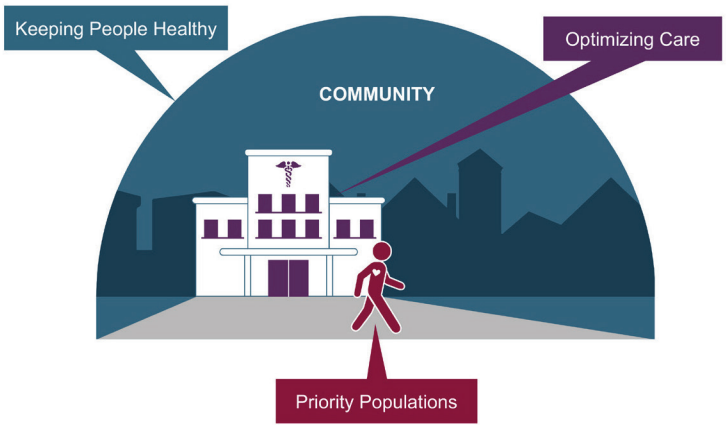
The only way we—as a nation—will meet the Million Hearts® goals is through the collective and focused action of a diverse range of partners.

As a Million Hearts® partner, determine where your individual or organizational mission aligns with the Million Hearts® priorities and explore the evidence-based strategies most suited to your talents, interests, and resources. Check out the **Million Hearts® 2022 framework** and commit with us to carry out the priority actions needed to prevent 1 million heart attacks and strokes.

## Million Hearts® 2022 Priorities

Million Hearts® has set the following priorities to meet the aim of preventing 1 million heart attacks and strokes by 2022:

- ***Keeping people healthy*** with public health efforts that promote healthier levels of sodium consumption, increased physical activity, and decreased tobacco use.
- ***Optimizing care*** by using teams, health information technology, and evidence-based processes to improve the ABCS (Aspirin when appropriate, Blood pressure control, Cholesterol management, and Smoking cessation), increase use of cardiac rehab, and enhance heart-healthy behaviors.
- ***Improving outcomes for priority populations*** selected based on data showing a significant cardiovascular health disparity, evidence of effective interventions, and partners ready to act. Populations include Blacks/African Americans, 35- to 64-year-olds, people who have had a heart attack or stroke, and people with mental illness or substance use disorders.

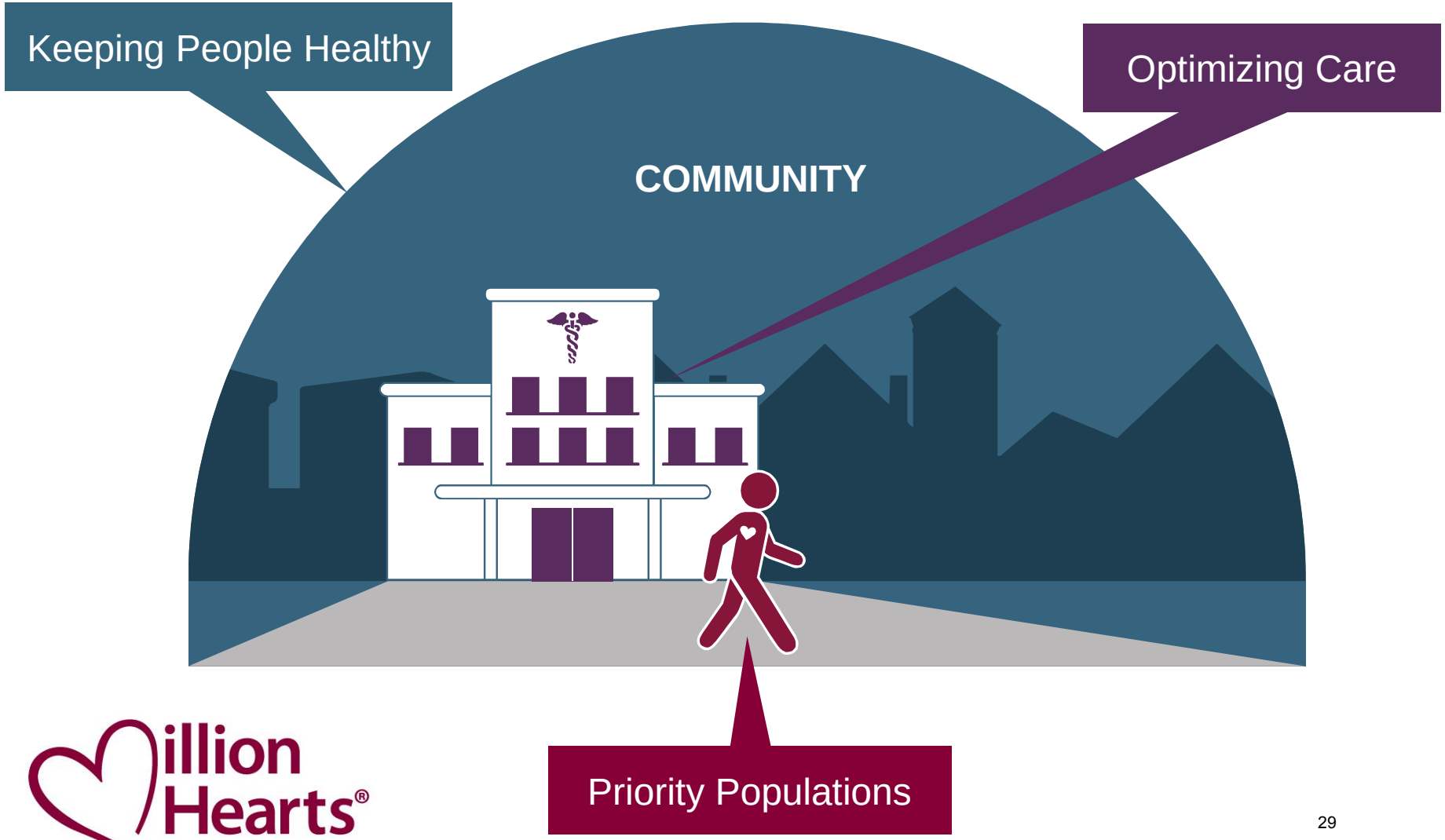





**Learn more by visiting millionhearts.hhs.gov**

April 2017

# Million Hearts® 2022
## *Design*



# Million Hearts® 2022
## *Priorities*

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

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

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

*Aspirin, Blood pressure control, Cholesterol management, Smoking cessation

Million Hearts®

# Keeping People Healthy

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

Million Hearts®

# Optimizing Care

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

Million Hearts®

*Aspirin, Blood pressure control, Cholesterol management, Smoking cessation

# Improving Outcomes for Priority Populations

| Priority Populations | Major Strategies |
|---|---|
| **Blacks/African-Americans** | Improving hypertension control |
| **35-64 year olds—because event rates are rising** | • Improving hypertension control and statin use<br>• Increasing physical activity |
| **People who have had a heart attack or stroke** | • Increasing cardiac rehab referral & participation<br>• Avoiding exposure to particulate matter |
| **People with mental illness or substance use disorders** | Reducing tobacco use |

Million Hearts®

# Tools and Resources

**http://www.heart.org**

## Online Tools

- **Check. Change. Control. Tracker** (https://www.ccctracker.com)
  A new online tool to help you track your blood pressure readings and connect with a volunteer health mentor to share your results and progress. Signing up is easy, you just need a campaign code which you can receive by contacting your local AHA affiliate who can also provide more information on the program. If there isn't an AHA office near you, go to www.ccctracker.com/aha and find the campaign code on the map for your state and sign up.

- **My Life Check** (http://tools.bigbeelabs.com/aha/tools/mlc/)
  Get a full heart health assessment with this tool based on many years of research.

- **Heart Attack Risk Calculator** (http://www.cvriskcalculator.com/)
  Calculate your 10-year risk of heart disease or stroke using the ASCVD algorithm published in 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk

- **High Blood Pressure Health Risk Calculator** (http://tools.bigbeelabs.com/aha/tools/hbp/)
  Enter your latest blood pressure reading to learn your risk of having a heart attack, a stroke, and developing heart failure and kidney disease. You'll also learn how a few lifestyle changes can lower your blood pressure and your health risks. You can print your risk report to review and discuss with your healthcare professional.

## Resources

- **Target: BP** (http://targetbp.org)
  Target: BP is a nationwide initiative aimed at controlling high blood pressure and reducing the growing number of Americans who have heart attacks and stroke. The initiative is co-led by the American Heart Association (AHA) and the American Medical Association (AMA) to help physicians, care teams and patients achieve better blood pressure control in accordance with current AHA guidelines.

- **EmPowered to Serve**
  (http://www.empoweredtoserve.org)
  A multicultural initiative that works to influence faith-based as well as urban housing channels to build strategic alliances that support a "culture of health" through healthy living, enhancing the chain of survival, and improving the environment.

- **Get With The Guidelines**
  (http://www.heart.org/HEARTORG/Professional/GetWithTheGuidelinesHFStroke/Get-With-The-Guidelines---HFStroke_UCM_001099_SubHomePage.jsp
  Get With The Guidelines programs are in-hospital programs for improving stroke, heart failure, resuscitation, and AFib care by promoting consistent adherence to
  the latest evidence-based practices. The program provides hospitals with access to: web-based Patient Management Tool™ (powered by Quintiles Real World and Late Phase Research), clinical decision support, robust registry, real-time benchmarking capabilities and other performance improvement methodologies toward the goal of enhancing patient outcomes and saving lives.

- **Check. Change. Control. (CCC)**
  (http://www.heart.org/HEARTORG/Conditions/More/ToolsForYourHeartHealth/Check-Change-iControli-Community-Partner-Resources_UCM_445512_Article.jsp#.WVQTmU0kvIU)
  Check. Change. *Control*. is an evidence-based hypertension management program that utilizes blood pressure self-monitoring to empower patients/participants to take ownership of their cardiovascular health. The program incorporates the concepts of remote monitoring and online tracking as key features to improve outcomes in hypertension management, physical activity, and weight reduction.
  - **Check. Change. Control. Cholesterol Patient Guide**
    (http://www.heart.org/mycholesterolguide)

- **AHA's Smoking Cessation Tools and Resources**
  http://www.heart.org/HEARTORG/GettingHealthy/QuitSmoking/Quit-Smoking_UCM_001085_SubHomePage.jsp

- **AHA Healthy Workplace Food and Beverage Toolkit July 2016**
  http://www.heart.org/HEARTORG/GettingHealthy/WorkplaceWellness/WorkplaceWellnessResources/Healthy-Workplace-Food-and-Beverage-Toolkit-Resources_UCM_465206_Article.jsp

# South Dakota
## 2017 Public Policy Agenda

*Building healthier lives, free of cardiovascular diseases and stroke.*

**Heart disease is the No. 1 killer of South Dakotans. The American Heart Association / American Stroke Association supports and advocates for public policies that will help improve the cardiovascular health of all Americans by 20 percent while reducing deaths from coronary heart disease and stroke by 20 percent by 2020.**

- **Access to Care: Medicaid Expansion**
  - Pass legislation to extend Medicaid in South Dakota to ensure access to preventive health care for residents up to 138 percent of federal poverty level

- **Quality Systems of Care: CPR in Schools**
  - Pass legislation or enact rules establishing hands-only CPR training in South Dakota schools

- **Healthy Living: Tobacco Free**
  - Defend South Dakota's comprehensive smoke-free law
  - Protect state tobacco prevention and control funding and work to increase program funding

- **Healthy Living: Nutrition & Physical Activity**
  - Support SD Department of Health efforts to increase the number of South Dakotans engaged in active living and healthy eating
  - Support local policy efforts by groups including Live Well Sioux Falls and Live Well Black Hills that work to create a healthier built environment

**Advancing Million Hearts®:**
**AHA and State Heart Disease and Stroke Partners Working Together in South Dakota**

July 11, 2017
9:00 AM to 3:00 PM CT

*Holiday Inn, Sioux Falls City Centre*
*100 W. 8th St.*
*Sioux Falls, South Dakota*

**Welcome & Overview of the Day**

**Julie Harvill, Operations Manager**
*Million Hearts® Collaboration*

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

**Expectations-Approach for the Day**
John Bartkus, *Principal Program Manager, Pensivia*

**Introductions:**

1. **Name**
2. **Organization**
3. **What excites you about your role in heart disease and stroke prevention?** *(one sentence)*

**Logistics – Preparing for Afternoon Breakouts**

| 1<br>IMPROVE DATA COLLECTION | 2<br>PRIORITY POPULATIONS | 3<br>CONTINUUM OF CARE | 4<br>PREVENTION & MANAGEMENT |
|---|---|---|---|
| **Ashley Miller**<br>Stan Kogan<br>Whitney Garney<br>Robin Rinker<br>Mallory Stasko | **Kiley Hump**<br>Julia Schneider<br>April Wallace<br>Linda Stopp | **Megan Myers**<br>Julie Harvill<br>Mary Jo Garofoli | **Katie Hill**<br>Miriam Patanian<br>John Clymer<br>Holly Arends |

**ACTION**: Before lunch is over,
please <u>add your name</u> to the Flip-chart
for the Session you plan to attend.

**A key focus for the day…**

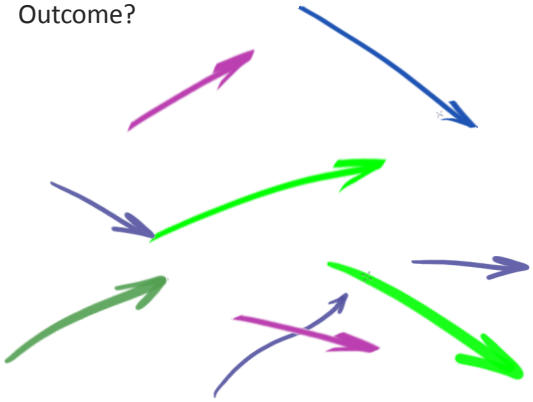
**ALIGNMENT**

## Activity

- "We're all Arrows"
- Look around the room.
  Identify something to focus on.
- Close your eyes.
- Fully extend your arm to point at it.
  *(Watch out for your neighbors)*

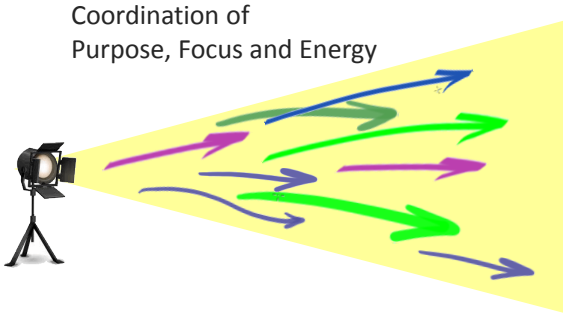
Million Hearts®

Outcome?



Alignment

Coordination of
Purpose, Focus and Energy



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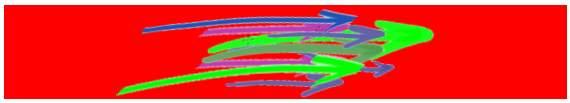
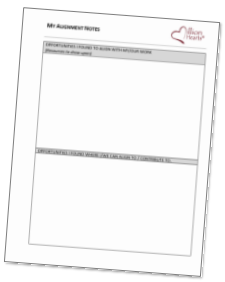


Higher Impact on the target

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



Opportunities I found to:
* Align with My work
* Align with Others work

If "Alignment" is a key goal of this meeting, then what would evidence of cultivating alignment be?

## Preventing 1 Million Heart Attacks and Strokes by 2022

**Robin Rinker, MPH**
**Health Communications Specialist**
**Division for Heart Disease and Stroke Prevention**
**Centers for Disease Control and Prevention**

Million Hearts®

## Million Hearts® 2022

- **Aim:** Prevent 1 million—or more—heart attacks and strokes in the next 5 years
- National initiative co-led by:
  - Centers for Disease Control and Prevention (CDC)
  - Centers for Medicare & Medicaid Services (CMS)
- Partners across federal and state agencies and private organizations

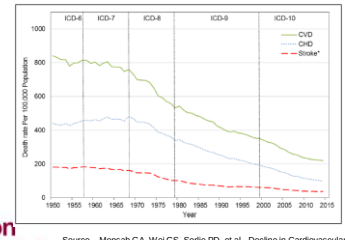
## Heart Disease and Stroke in the U.S.

- More than **1.5 million** people in the U.S. suffer from heart attacks and strokes per year[1]
- More than **800,000** deaths per year from cardiovascular disease (CVD)[1]
- CVD costs the U.S. **hundreds of billions** of dollars per year[1]
- CVD is the greatest contributor to racial disparities in life expectancy[2]

References
1. Benjamin EJ, Blaha MJ, Chiuve SE, Cushman M, Das SR, Deo R, et al. Heart Disease and Stroke Statistics-2017 Update: A Report From the American Heart Association. Circulation 2017;135(10):e146–603.
2. Kochanek KD, Arias E, Anderson RN. How did cause of death contribute to racial differences in life expectancy in the United States in 2010? NCHS data brief, no 125. Hyattsville, MD: National Center for Health Statistics. 2013

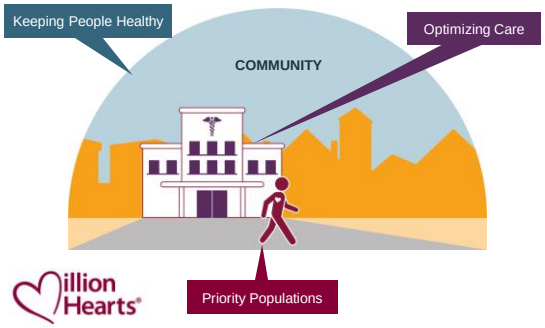
## Heart Disease and Stroke Trends 1950-2015

While CV deaths have been declining for the past 40 years, the **reduction in these deaths has slowed**.




Source – Mensah GA, Wei GS, Sorlie PD, et al. Decline in Cardiovascular Mortality – Possible Causes and Implications. Circulation Research. 2017;120:366-380.

## Million Hearts® 2022
*Aim: Prevent 1 Million Heart Attacks and Strokes in 5 Years*




## Million Hearts® 2022
*Priorities*

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

| Optimizing Care |
|---|
| Improve ABCS* |
| Increase Use of Cardiac Rehab |
| 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 illness or substance use disorders |

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

## Keeping People Healthy

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

## Optimizing Care

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

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

## Improving Outcomes for Priority Populations

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

## Million Hearts® Resources and Tools

- **Action Guides**—Hypertension control; Self-measured blood pressure monitoring (SMBP); Tobacco cessation; Medication adherence
- **Protocols**—Hypertension treatment; Tobacco cessation; Cholesterol management
- **Tools**—Hypertension prevalence estimator; ASCVD risk estimator
- **Health IT**
- **Clinical Quality Measures**
- **Consumer Resources and Tools**

## Partner Opportunities: Hospitals *Sample Actions to Consider*

- **Action:** Make healthy food and beverage choices available to patients, visitors, and staff
  - **Resource:** HHS/GSA Health and Sustainability Guidelines for Federal Concessions and Vending Operations
  - **Success Story:** Sodium Reduction Community Program Los Angeles County Department of Public Health
- **Action:** Implement comprehensive smoke-free policies
  - **Resource:** The Community Guide: Tobacco Use and Secondhand Smoke Exposure: Smoke-Free Policies
  - **Success Story:** Communities Putting Prevention to Work: Tobacco Use Prevention and Control
- **Action:** Institute automatic referral of eligible patients to cardiac rehab
  - **Resource:** Increasing Cardiac Rehabilitation Participation From 20% to 70%: A Road Map From the Million Hearts Cardiac Rehabilitation Collaborative

## Partner Opportunities: Employers *Sample Actions to Consider*

- **Action:** Make healthy food and beverage choices available to all employees
  - **Resource:** HHS/GSA Health and Sustainability Guidelines for Federal Concessions and Vending Operations
  - **Success Story:** Sodium Reduction Community Program Los Angeles County Department of Public Health
- **Action:** Develop and support policies at worksites to encourage use of tobacco cessation services.
  - **Resource:** The Community Guide: Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions
  - **Success Story:** North Carolina Division of Public Health, Tobacco Prevention and Control Branch: Expanding Comprehensive Coverage for Tobacco Cessation
- **Action:** Provide environmental supports for recreation or physical activity (e.g., onsite exercise facility, walking trails, bicycle racks).
  - **Resource:** CDC Worksite Health ScoreCard
  - **Success Story:** Bike Share Program Offers California State Employees Another Way to Be Active

## Partner Opportunities: Clinical Care Teams *Sample Actions to Consider*

- **Action:** Use standardized treatment protocols for hypertension treatment, tobacco cessation, and cholesterol management
  - **Resource:** CDC: Million Hearts® Protocols
  - **Success Story:** 2014 Hypertension Control Champions: Large Health Systems
- **Action:** Implement self-measured blood pressure monitoring (SMBP) interventions with clinical support
  - **Resource:** Million Hearts® Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians
  - **Success Stories:** 2013 Hypertension Control Champion: Nilesh V. Patel, MD; 2015 Hypertension Control Champion: Reliant Medical Group
- **Action:** Improve performance on Million Hearts® clinical quality measures on aspirin, BP control, cholesterol, smoking cessation, and cardiac rehab
  - **Resource:** Million Hearts® ABCS measures
  - **Success Story:** Association of State and Territorial Health Officials (ASTHO) Million Hearts Minnesota
- **Action:** Leverage electronic health record (EHR) systems to excel in the ABCS
  - **Resource:** Million Hearts® EHR Optimization Guides
  - **Success Story:** Michigan Center for Effective IT Adoption

## Stay Connected

- Million Hearts® eUpdate Newsletter
- Million Hearts® on Facebook and Twitter
- Million Hearts® Website
- Million Hearts® for Clinicians Microsite


## Million Hearts® for Clinicians Microsite

- Features Million Hearts® protocols, action guides, and other QI tools
- Syndicates **LIVE** Million Hearts® on your website for your clinical audience
- Requires a small amount of HTML code—customizable by color and responsive to layouts and screen sizes
- Content is free, cleared, and continuously maintained by CDC

Available at https://tools.cdc.gov/medialibrary/index.aspx#/microsite/id/279017

## Q & A

**Group Interaction**

## Break

SOUTH DAKOTA DEPARTMENT OF HEALTH


KILEY HUMP, ADMINISTRATOR

OFFICE OF CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

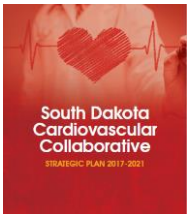

## DOH STRATEGIC PLAN 2015-2020

| | |
|---|---|
| VISION | Healthy People<br>Healthy Communities<br>Healthy South Dakota |
| MISSION | To promote, protect and improve the health of every South Dakotan |
| GUIDING PRINCIPALS | Serve with integrity<br>Eliminate health disparities<br>Demonstrate leadership and accountability<br>Focus on prevention and outcomes<br>Leverage partnerships<br>Promote innovation |

GOOD & HEALTHY SOUTH DAKOTA

OFFICE OF CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

## The Cardiovascular Collaborative



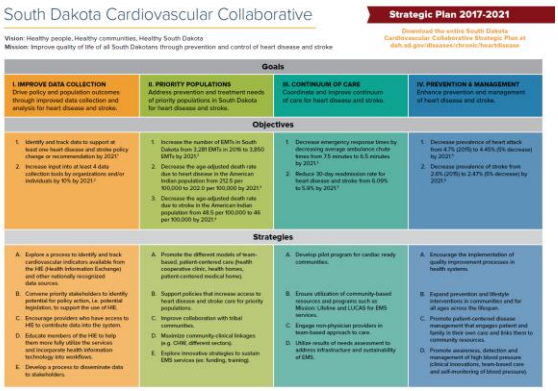

A group of medical and public health representatives who want to improve the quality of life for all South Dakotans through prevention and control of heart disease and stroke.

## Leadership Team

- Holly Arends
- Kevin Atkins
- Mandi Atkins
- Stacie Davis
- Mark East
- Colette Hesla
- Katie Hill
- Kiley Hump
- Amanda Keefe
- Marty Link
- Mary Michaels
- Ashley Miller
- Megan Myers

*Have a conference call quarterly

## Collaborative Planning Process



South Dakota Cardiovascular Collaborative

Strategic Plan 2017-2021

Vision: Healthy people, Healthy communities, Healthy South Dakota

Mission: Improve quality of life of all South Dakotans through prevention and control of heart disease and stroke

Goals

| I. IMPROVE DATA COLLECTION | II. PRIORITY POPULATIONS | III. CONTINUUM OF CARE | IV. PREVENTION & MANAGEMENT |
|---|---|---|---|
| Drive policy and population outcomes through improved data collection and analysis for heart disease and stroke. | Address prevention and treatment needs of priority populations in South Dakota for heart disease and stroke. | Coordinate and improve continuum of care for heart disease and stroke. | Enhance prevention and management of heart disease and stroke. |

Objectives

| I. IMPROVE DATA COLLECTION | II. PRIORITY POPULATIONS | III. CONTINUUM OF CARE | IV. PREVENTION & MANAGEMENT |
|---|---|---|---|
| 1. Identify and track data to support at least one heart disease and stroke policy change or recommendation by 2021.<br>2. Increase input into at least 4 data collection tools by organizations and/or individuals by 10% by 2021. | 1. Increase the number of EMTs in South Dakota from 3,281 EMTs in 2016 to 3,850 EMTs by 2021.<br>2. Decrease the age-adjusted death rate due to heart disease in the American Indian population from 212.5 per 100,000 to 202.0 per 100,000 by 2021.<br>3. Decrease the age-adjusted death rate due to stroke in the American Indian population from 48.5 per 100,000 to 46 per 100,000 by 2021. | 1. Decrease emergency response times by decreasing average ambulance chute times from 7.5 minutes to 6.5 minutes by 2021.<br>2. Reduce 30-day readmission rate for heart disease and stroke from 6.09% to 5.9% by 2021. | 1. Decrease prevalence of heart attack from 4.7% (2015) to 4.45% (5% decrease) by 2021.<br>2. Decrease prevalence of stroke from 2.6% (2015) to 2.47% (5% decrease) by 2021. |

Strategies

| I. IMPROVE DATA COLLECTION | II. PRIORITY POPULATIONS | III. CONTINUUM OF CARE | IV. PREVENTION & MANAGEMENT |
|---|---|---|---|
| A. Explore a process to identify and track cardiovascular indicators available from the HIE (Health Information Exchange) and other nationally recognized data sources.<br>B. Convene priority stakeholders to identify potential for policy action, i.e. potential legislation, to support the use of HIE.<br>C. Encourage providers who have access to HIE to contribute data into the system.<br>D. Educate members of the HIE to help them more fully utilize the services and incorporate health information technology into workflows.<br>E. Develop a process to disseminate data to stakeholders. | A. Promote the different models of team-based, patient-centered care (health cooperative clinic, health homes, patient-centered medical home).<br>B. Support policies that increase access to heart disease and stroke care for priority populations.<br>C. Improve collaboration with tribal communities.<br>D. Maximize community-clinical linkages (e.g. CHW, different sectors).<br>E. Explore innovative strategies to sustain EMS services (ex: funding, training). | A. Develop pilot program for cardiac ready communities.<br>B. Ensure utilization of community-based resources and programs such as Mission: Lifeline and LUCAS for EMS services.<br>C. Engage non-physician providers in team-based approach to care.<br>D. Utilize results of needs assessment to address infrastructure and sustainability of EMS. | A. Encourage the implementation of quality improvement processes in health systems.<br>B. Expand prevention and lifestyle interventions in communities and for all ages across the lifespan.<br>C. Promote patient-centered disease management that engages patient and family in their own care and links them to community resources.<br>D. Promote awareness, detection and management of high blood pressure (clinical innovations, team-based care and self-monitoring of blood pressure). |

## Year 1 Implementation

- In-person Action Planning meeting March 2017
- Selected Year 1 Priority Strategy in each goal area
- Workgroup calls
- Advancing Million Hearts Conference

Million Hearts®

## Q & A

## Group Interaction

# Improving Cardiac Care- the Great Plains States

**Holly Arends**, Program Manager
South Dakota Foundation for Medical Care

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains Quality Innovation Network

## Great Plains Quality Innovation Network (GPQIN)


- Antibiotic Stewardship
- Cancer Prevention
- Cardiac Health
- Care Coordination
- Diabetes Care
- Healthcare Infections
- Immunizations
- Medication Safety
- Nursing Home Care
- Quality Payment Program
- Transforming Clinical Practice
- Colorectal Cancer Screening

## Triple AIM Approach to Clinical Quality

- Better Health
- Better Care
- Lower Cost

**Foundation Principles:**

- Enable innovation
- Foster learning organizations
- Eliminate disparities
- Strengthen infrastructure and data systems

## Our Approach

- Align with the Million Hearts® Initiative (www.millionhearts.hhs.gov) to improve preventive care measures, including aspirin use, blood pressure control, cholesterol management and smoking/tobacco education
- We will target disparate populations, including gender, racial and ethnic disparities and rural, to improve cardiac health

## Our Approach

- Focus on the ABCS
  - Measure monitoring
    - HHQI
    - MIPS Calculator
    - Practice Pattern Variance
  - Data driven QI
  - Optimizing utilization of HIT
  - Support innovations in care delivery

## Cardiovascular Health and Million Hearts®

Our planned improvement efforts align with the national Million Hearts® initiative that seeks to prevent one million heart attacks and strokes by 2022.

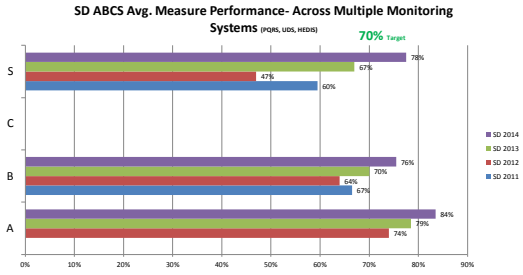
- Heart disease and stroke are the first- and fourth-leading causes of death[1]
- Heart disease and stroke cost more than $312.6 billion in healthcare expenditures and lost productivity annually[2]

*1. Centers for Disease Control and Prevention*
*2. Million Hearts®*

## Our Approach

- Offering technical assistance on the Physician Quality Reporting System (PQRS) cardiovascular measures submission for participating clinics
- Assist home health agencies with measures reporting through the Home Health Cardiovascular Data Registry
- Help clinics utilize EHRs for data analysis and performance improvement activities focused on clinical quality measures

## South Dakota Performance




## Contact Information


Holly Arends, CMQP
Program Manager
Great Plains QIN/ SDFMC
P: 605.660.5436
Holly.Arends@area-a.hcqis.org



This material was prepared the Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for Kansas, Nebraska, North Dakota and South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-GPQIN-GEN-01/0914


Million Hearts®

**Q & A**

## Overview of the American Heart Association and Programs and Resources that align with Million Hearts®


Megan Myers
SD Government Relations Director


American Heart Association | American Stroke Association
life is why

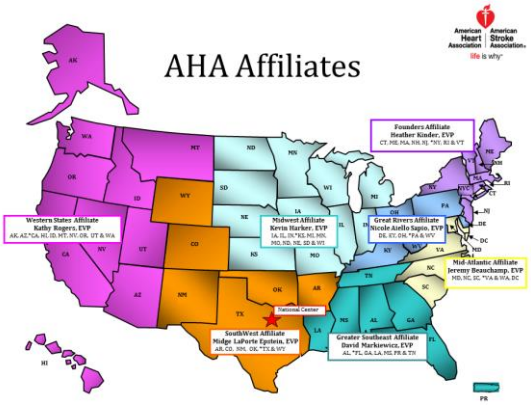
**Mission**

Building healthier lives, free of cardiovascular diseases and stroke.

**Our 2020 Impact Goal**

By 2020 to improve the cardiovascular health of all Americans by 20% while reducing deaths from cardiovascular diseases and stroke by 20%.

## AHA Affiliates




## Building a Culture of Health

A culture in which people live, work, learn, play and pray in environments that support healthy behaviors, timely quality care and overall well-being.

## AHA and Million Hearts® Spotlight on South Dakota

Quality & Systems Improvement Priorities

*Get With The Guidelines & Mission: Lifeline Quality Awards*

- Avera Heart Hospital of South Dakota
- Sanford USD Medical Center
- Rapid City Regional Hospital


## AHA and Million Hearts® Spotlight on South Dakota

Quality & Systems Improvement Priorities

*2017 Mission: Lifeline EMS Recognition*

- Paramedics Plus – Sioux Falls
  - Sioux Falls Fire Rescue
  - Sioux Falls Police
- Moody County Ambulance - Flandreau


## AHA and Million Hearts® Spotlight on South Dakota

**Advocacy**

- **Policy Goals**

  Organized by category, based on scientific research and modified each year based on latest data and how many people impacted

- **You're the Cure Network, SD Advocacy Committee**

  Grassroots advocacy network and statewide grasstops advocates

# AHA and Million Hearts® Spotlight on South Dakota

**Advocacy Priorities**

- Health Insurance Coverage – Medicaid Expansion/Reform
- Systems of Care – Stroke and STEMI Designations and Registries, Cardiac-Ready Communities
- Healthy Living – Complete Streets, Healthy SD
- Tobacco-Free – Smoke Free SD, Tobacco Prevention/Control

# CPR in Schools

- South Dakota was 36th state to require hands-only CPR in required curriculum before graduation
- Became law July 1, 2017
- Could train up to 10,000 students a year in bystander CPR and greatly enhance our emergency services capacity in South Dakota

# Cardiac-Ready Communities

- Program designed to prepare communities to respond and assist to increase survival from a cardiac event occurring outside of the hospital setting
- North Dakota, Montana, Minnesota have similar programs, SD gathering best practices

# Healthy Living

- Support efforts to increase active living and healthy eating through policy
- Complete Streets, Safe Routes to School, bike safety laws
- Increasing quality and quantity of physical activity in schools
- Supporting school lunch standards

# Tobacco-Free

- Reduce tobacco use in South Dakota
- Increasing price of tobacco products – 2006
- Defending our smoke-free law – passed 2010
- Working to ensure the US Food and Drug Administration has the authority to regulate tobacco, including e-cigarettes
- Work annually in Pierre on enforcement and program funding


## 1) Blood Pressure Strategies

**Increase and sustain blood pressure control** from 54% to over 70% through healthcare system participation in Target BP — **IMPACT:** 7-12.5M

**Increase % of hypertensive patients that are self-monitoring** through community and employer based SMBP programs *(Y-BP and CCC)* — **IMPACT:** 500K (Complementary)

**Implement policy agenda** to support increased hypertension control *(home monitor coverage, Y-BP coverage, etc.)*

*Current Prevalence:*

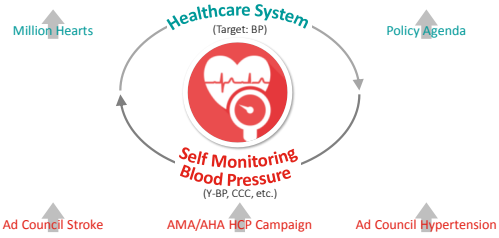
**33 Million**

Number of Adults 20+ with blood pressure >140/90 and/or BP medication use (NHANES 13-14)

**Health Equity Priority Populations**

- Highest prevalence: Black Adults (19% of total), Hispanic Adults (16% of total)
- Impact on Health Disparities: Twin approach focus on FQHCs and community clinics

## Blood Pressure Ecosystem




American Heart Association. life is why®

Check. Change. *Control.* CHOLESTEROL™

Nationally supported by Sanofi and Regeneron
& supporting the 2020 AHA/ASA Impact Goal,
Check. Change. ***Control.*** Cholesterol ™
will empower all Americans to better manage their cholesterol
through the knowledge, tools, and resources needed
to reduce their risk for cardiovascular disease.

National Supporter
SANOFI REGENERON

## Objectives

American Heart Association. life is why® | Check. Change. Control. CHOLESTEROL

- Increase adoption and utilization of cholesterol management guidelines through professional education and quality improvement programs.
- Increase understanding of and adherence to evidence-based treatment guidelines through public and patient education.

## National Cholesterol Initiative Goals

- To set up a **pilot program in an Integrated Delivery Network with 50 healthcare providers** by summer 2018.
- Within the pilot program, achieve a 10% improvement in **clinical management** of cholesterol and a 10% improvement in **perceptions of self-management** of cholesterol in patients with **existing cardiovascular disease** (CVD) and patients **at high risk for CVD** by November 2018.

| 10% improvement in clinical management | 10% improvement in perceptions of self-management |
|---|---|
| **Sub-goal 1:** Achieve a 10% increase in percentage of adult patients with existing atherosclerotic cardiovascular disease (ASCVD) or at high risk for the development of ASCVD who are prescribed statin therapy. (PQRS #438 + additional reporting for groups with ASCVD risk > 7.5%)<br>**Sub-goal 2:** Achieve a 10% improvement in provider-reported utilization of lifestyle-based treatment practices for cholesterol management. | **Sub-goal 3:** Achieve a 10% improvement in self-reported patient outcomes focused on self-management of health conditions, including cholesterol. |

- Concurrent to the pilot effort, prepare for **national population roll out** launching in Spring 2018.

***2020 Goal & Plan Alignment:*** Based on the pilot settings, the Center for Health Metrics & Evaluation is advising on scenarios to extrapolate the potential for impact of this clinical management measure nationally. This will guide our national scale strategy in alignment with the 2020 goal measure (total cholesterol) and the 2017-2020 plan.

## Public Awareness, Patient Engagement & Empowerment

*Strategy: Increase public awareness, education and engagement of patients and family caregivers to improve understanding of cholesterol treatment and management.*

**Actions Taken:**

- ✓ Conducted market research with patients to understand gaps in perceived understanding and knowledge to inform educational efforts, as well as to identify news hooks for media launch, ongoing media outreach and new content.
- ✓ Planning is underway for consumer education campaign launch.
- ✓ Conducted content audit of Heart.org/Cholesterol and began refresh of content and tools.

**Next Steps:**

- Release refreshed content on Heart.org/Cholesterol in April 2017.
- Conduct consumer media campaign launch and begin continuous outreach via owned, earned and paid media channels in April 2017.
- Conduct Public Health Summit on April 11th 2017.
- Develop post-summit action plan, distribute to summit participants and conduct ongoing follow-up with participants to inform future efforts and further reach and impact of the initiative.

## Strategic Approach

**Public Health Summit:** Convene thought-leaders to discuss gaps in care to drive better cholesterol management.

Increase adoption and utilization of treatment guidelines through quality improvement programs and professional education.

Increase understanding of and adherence to evidence-based treatment guidelines through public and patient awareness and education.

**Quality Improvement & Professional Education**

- eCQM & PROM development
- Pilot measures and quality improvement program in an Integrated Delivery Network
- National rollout of measures and quality improvement program
- Continuing education

**Public Awareness & Patient Education/Empowerment**

- Informed by patient and provider market research
- Awareness and educational messages deployed via a robust campaign


## Tools and Resources

**Online Tools**

- My Life Check
- Heart Attack Risk Calculator
- AHA's Smoking Cessation Tools and Resources
- AHA Healthy Workplace Food and Beverage Toolkit July 2016

**Resources**

- EmPowered to Serve
- Get With The Guidelines
- Check.Change.Control
- Target: BP

## Discussion

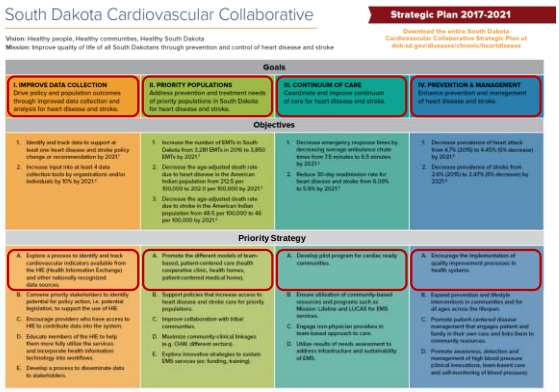
1. Is there a program you were unaware of that you would like to explore further for implementation or application in the state?
2. On which topics would you like additional information?
3. Other questions

## Contact Information

- Megan Myers, SD Government Relations Director
  - Sioux Falls
  - 605-261-7717
  - megan.myers@heart.org
  - @MeganAtHeart
- Pam Miller, Regional Grassroots Advocacy Director
  - Brookings
  - 605-310-3170
  - pamela.miller@heart.org

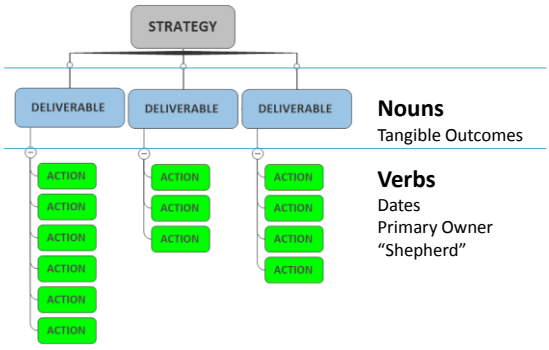
**Facebook.com/southdakotaheart**

**@sdakotaheart**



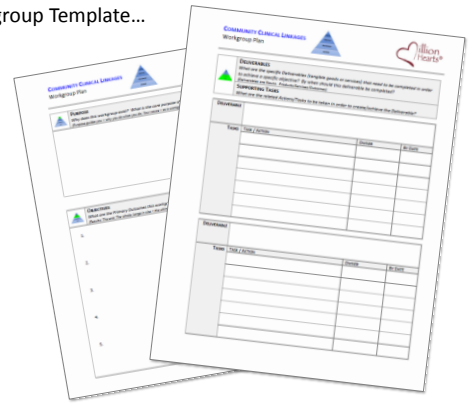
## Workgroup Approach



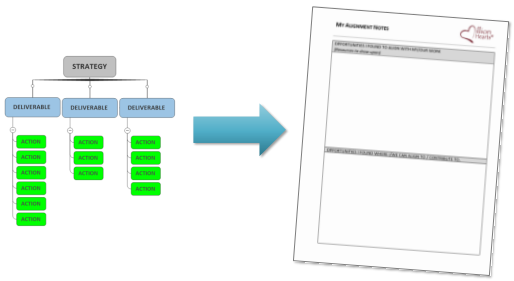

**Nouns**
Tangible Outcomes

**Verbs**
Dates
Primary Owner
"Shepherd"

Workgroup Template…



## Use this Conversation about an Action Plan as a Vehicle to Identify & Cultivate Alignment.




**Final Logistics –for Afternoon Breakouts**

| 1 IMPROVE DATA COLLECTION | 2 PRIORITY POPULATIONS | 3 CONTINUUM OF CARE | 4 PREVENTION & MANAGEMENT |
|---|---|---|---|
| **Ashley Miller**<br>Stan Kogan<br>Whitney Garney<br>Robin Rinker<br>Mallory Stasko | **Kiley Hump**<br>Julia Schneider<br>April Wallace<br>Linda Stopp | **Megan Myers**<br>Julie Harvill<br>Mary Jo Garofoli | **Katie Hill**<br>Miriam Patanian<br>John Clymer<br>Holly Arends |
| | | | |

2:00pm – Groups provide "Report Outs" to the full team

## REPORTS FROM BREAKOUTS

## PLANS FOR FOLLOW-UP/NEXT INTERACTIONS

*John Bartkus*

## EVALUATION AND FEEDBACK PROCESS

*Whitney R. Garney, WRG Consulting*

## WRAP UP

*April Wallace, Program Initiatives Manager, Million Hearts® Collaboration*

## ADJOURN