Advancing Million Hearts®:
AHA and Heart Disease and Stroke Prevention Partners Working Together in West Virginia

August 23, 2017
Meeting Summary

Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in West Virginia

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Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in West Virginia

The American Heart Association hosted a successful meeting Million Hearts® Collaboration meeting with its West Virginia partners on Aug. 23, 2017. Participants refined priorities, expanded networks and shared resources that will help advance the collaboration's principle goal of preventing one million heart attacks, strokes, and other cardiovascular events over the next five years.

The productive meeting involved the contributions of 62 participants, representing 51 organizations (*9 of which represent Programs, Divisions and Offices within the State Health Department and or the Department of Health and Human Resources*).

West Virginia's dedicated partners recognized the need to better align their work to support the

areas and discussed how to accomplish that objective:

- Community Health Workers: Engage community health workers to use a team-based care model to lower cholesterol and blood pressure rates. In minority and underserved communities, use additional interventions such as social support and culturally appropriate education to help reduce health disparities.
- Community Pharmacists/ Physicians: Link physicians with pharmacists to encourage collaborative practice agreements. Help train pharmacists to become health coaches who can suggest lifestyle changes to patients with diabetes, hypertension and other chronic, but manageable, illnesses.
- Hypertension Control: Assess available needs, and start a listserv to continually share resources within the community. Examine protocols area healthcare workers are practicing, and work together to promote treatment procedures.
- Medication Adherence: Assess available resources, current workforce needs, and payer coverage related to hypertension control. Work with Board of Pharmacy on creating a task force. Standardize a medical safety list.
- Team-based Care: Better explain the role of community health workers and identify existing team-based protocols, particularly for rural areas. Recruit

Participants left the meeting with firm, actionable next steps a clearer perspective on how their work aligns with and continues to support Million Hearts® priorities.

Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in West Virginia

WEDNESDAY, AUGUST 23, 2017

9:00 AM - 3:00 PM ET

(Networking starts at 8:30 AM)

Four Points by Sheraton Charleston
600 Kanawha Blvd East
Charleston, West Virginia 25301

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

8:30 AM **PARTNER NETWORKING**

9:00 AM **WELCOME**
Julie Harvill
Operations Manager, Million Hearts® Collaboration

OVERVIEW OF THE DAY
John Clymer
Executive Director, National Forum for Heart Disease and Stroke Prevention
Co-chair, Million Hearts® Collaboration

9:05 AM **INTRODUCTIONS & FOCUS ON ALIGNMENT**
John Bartkus
Pensivia

In one sentence, what excites you about your role in heart disease and stroke prevention?

9:40 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 AND A / GROUP INTERACTION

10:30 AM **BREAK**

10:45 AM **WEST VIRGINIA BUREAU FOR PUBLIC HEALTH ADDRESS PRIORITIES THAT ALIGN WITH MILLION HEARTS®**
Jessica G. Wright, RN, MPH, CHES
Director, Health Promotion and Chronic Disease;

Melissa Raynes
Director, Office of Emergency Medical Services

Barbara Miller, RN
WISEWOMAN

Q AND A

11:05 AM **QUALITY INSIGHT ADDRESS THEIR WORK AND ALIGNMENT WITH MILLION HEARTS®**
Debbie L. Hennen, RN
Project Coordinator, Quality Insights

Q AND A / GROUP DISCUSSION

11:20 AM **AHA/ASA PROGRAMS AND RESOURCES THAT ALIGN WITH MILLION HEARTS®**
Christine Compton, MPH
Government Relations Director, American Heart Association for West Virginia

Cynthia A. Keely, BA, RRT, LRTR
Director, Quality and Systems Improvement, American Heart Association

Q AND A

CATERED LUNCH

11:35 AM

AFTERNOON BREAKOUTS/FACILITATED DISCUSSIONS

12:15 PM John Bartkus and Group Leads

Program efforts that align and ways to work together

- Community Health Workers
- Community Pharmacists/Physicians
- Hypertension Control
- Medication Adherence
- Team Based Care

REPORT-OUTS FROM WORKGROUPS & PLANS FOR FOLLOW-UP

2:10 PM John Bartkus

EVALUATION AND FEEDBACK PROCESS

2:50 PM Whitney Garney

WRAP UP / ADJOURN

2:55 PM April Wallace

REGISTRANTS AS OF AUGUST 14, 2017

American Heart Association ■ Anthem ■ Cabell Huntington Hospital ■ Camden Clark Medical Center ■ Center for Local Health ■ Centers for Disease Control and Prevention ■ Charleston Internal Medicine ■ Community Care of West Virginia ■ Davis Medical Center ■ DaVita ■ Dignity Hospice & Home Health ■ Division of Health Promotion and Chronic Disease ■ Health Quality Innovators ■ Healthy Bodies Healthy Spirits West Virginia ■ Huntington Internal Medicine Group ■ Kindred at Home ■ Logan Regional Medical Center ■ Mingo Wayne Home Health ■ Minnie Hamilton Health System ■ Mountain State Medicine & Rheumatology, PLLC ■ National Association of Chronic Disease Directors ■ National Forum for Heart Disease & Stroke Prevention ■ Pensivia ■ Quality Insights ■ Home Health Quality Improvement ■ St. Mary's Medical Center ■ Thomas Health System ■ UniCare Health Plan of West Virginia ■ United Mine Workers of America Health and Retirement Funds ■ University of Charleston ■ West Virginia Caring ■ West Virginia Department of Health and Human Resources ■ Bureau for Public Health ■ Office of Community Health Systems and Health Promotion ■ West Virginia Health Promotion and Chronic Disease ■ West Virginia Health Statistics Center ■ West Virginia Hospital Association ■ West Virginia Medicaid ■ West Virginia Office Emergency Medical Services ■ West Virginia Rural Health Association ■ West Virginia School of Osteopathic Medicine ■ Center for Rural and Community Health ■ West Virginia State Medical Association ■ West Virginia University School of Pharmacy ■ West Virginia University Hospital ■ West Virginia University Medicine ■ West Virginia University Medicine Potomac Valley Hospital ■ West Virginia University School of Public Health ■ Office of Health Services Research ■ West Virginia WISEWOMAN Program ■ Wheeling Hospital

Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in South Dakota
Wednesday, August 23, 2017
Four Points By Sheraton Charleston

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Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention
Partners Working Together in West Virginia
August 23, 2017

Meeting Summary

West Virginia has a strong group of dedicated partners who recognize the need to align their work to better meet their ultimate vision. Several major themes emerged during the meeting that address five priority action areas:

- Community Health Workers
- Community Pharmacists/ Physicians
- Hypertension Control
- Medication Adherence
- Team-based Care

Themes:

- Providing resources to help providers and practices address cardiovascular health and hypertension through standard protocols and accurate BP measurement.
- Leveraging policy opportunities and aligning data sources (such as the Home Health Cardiovascular Data Registry; Chronic Disease Electronic Management System).
- Addressing medication adherence/medication safety and working with patients.
- Supporting non-physician team members such as pharmacists and community health workers.
- Developing a stroke system of a care and stroke with specific protocols.
- Increasing utilization of cardiac rehab and addressing challenges such as cost/access issues

Participants were asked to introduce themselves and state what they are excited about:

"Digging into the data and improving our processes and outcomes"
"Looking beyond our local region to work with others to address stroke"
"Clinical process development, data, and outreach into the community"
"It's not just one patient at a time; it's the whole state. We need to focus on data and outreach"
"Standardizing the care we provide to our patients and promoting wellness"
"This work will not only save lives around the state but will also save the life of someone I know"
"Addressing these issues in a systemic way for the state"
"Taking tools back to the public"
"Learning about initiatives that are addressing heart disease and stroke in West Virginia"

Action Areas Workplans:
Groups were asked to report out on the following areas:

- **WHAT TO FOCUS ON**
  - **CURRENT STATE / CONTEXT (Where are we now?)**
    - Sharing - What are each of us/organizations focusing on in this space?
    - What has been successful (strategies and practices)?
    - What are the key challenges?
    - What are the issues we're seeking to address?
  - **CULTIVATING COLLABORATION / ALIGNMENT / OBJECTIVES**
    - What do we choose to solve/focus on?
    - In which areas can we work together? How? What would this look like?
    - What objectives do we seek to accomplish?

- **HOW TO GET IT DONE**
    - **DELIVERABLES / ACTIONS**
      What are specific deliverables?
    - What actions/tasks need to be carried out in order to complete each Deliverable?
  - **SUSTAINABILITY / MOMENTUM**
    - How does this group keep the momentum going and carry forward this effort through to action and results?
    - When do we next meet?

GROUP 1: COMMUNITY HEALTH WORKERS		
Participants:		
Sandra Burrell	Bijal Patel	Josh Sowards
Sandra Ellis	Martha Power	Rhonda Boso Suggs
Scott Eubanks	Sherry Rockwell	Cindy Sun
Joyce Martin	Susan Sims	Emma White
Discussion Leads:	*Flip Chart Notes:*	*Notetaker:*
Adam Baus Scott Eubank	Whitney Garney	Julie Harvill

Topic Areas:
What's going on in WV? Is this applicable to addressing CVD?
Different roles? Payer's role?
Million Hearts and CDC Resources
Data Sources

OVERVIEW
The Community Preventive Services Task Force (CPSTF) recommends interventions that engage community health workers to prevent cardiovascular disease (CVD) among clients at increased risk. The Task Force finds strong evidence of effectiveness for interventions that engage community health workers in a team-based care model to improve blood pressure and cholesterol. They find sufficient evidence of effectiveness for interventions that engage community health workers for health education, and as outreach, enrollment, and information agents to increase self-reported health behaviors (physical activity, healthful eating habits, and smoking cessation) in clients at increased risk for CVD. Economic evidence indicates these interventions are cost-effective. A small number of studies suggest

that engaging community health workers improves appropriate use of healthcare services and reduces morbidity and mortality related to CVD. When interventions engaging community health workers are implemented in minority or underserved communities, they can improve health, reduce health disparities, and enhance health equity.

Interventions that engage community health workers to prevent cardiovascular disease aim to reduce risk factors among those at higher risk by providing culturally appropriate education, offering social support and informal counseling, connecting people with services, and in some cases delivering health services such as blood pressure screening. Community health workers (including promotores de salud, community health representatives, community health advisors, and others) are frontline public health workers who serve as a bridge between underserved communities and healthcare systems. They typically are from or have a unique understanding of the community served. Community health workers often receive on-the-job training and work without professional titles. Organizations may hire paid community health workers or recruit volunteers.
https://www.thecommunityguide.org/findings/cardiovascular-disease-prevention-and-control-interventions-engaging-community-health
CDC CHW resources:

- https://www.cdc.gov/dhdsp/pubs/chw-toolkit.htm
  - Everything you ever wanted to know about CHWs
  - Sodium fotonovela under 'Training and Education Resources'
- Might be interesting if they're talking policy https://www.cdc.gov/dhdsp/pubs/docs/SLFS-Summary-State-CHW-Laws.pdf
  - State Law Factsheet on what laws and regs states have re: CHWs

DISCUSSION
The WHAT
What are the issues your organization is seeking to address?
What has been successful (strategies and practices)?

- Definition – crafting what this is- National Definitions
- Integration as part of team
- Easier access point
- Training
- Certification
- What works?
- What needs improved?
- How do they do their jobs
- Church ministries
- Lay persons – 8th grade reading level

What are the key challenges?

- Struggle with resources being housed at the same place, so everyone can go to the same place to access information.
- Struggle with continuity of CHWs because once funding ends they are no longer employed and then new people come into the community who the people don't know
- Need an overarching definition of what a CHW is
- Common training or certification that CHWs can take (not too restrictive, so people aren't discouraged by the training)

What do we choose to focus on?
What would success look like for this work?

What objectives do we seek to accomplish?

Actions

- Medication adherence
- Relationships/Commonalities
- Referral system
- CHW Registry
- Create a system of training levels
- Clearinghouse
- CME's for continuing education

The HOW

- **How do we accomplish this? What specific actions or tasks need to be carried out in order to complete each step?**
- **Who can we increase awareness of existing or new resources?**
- **How do we want to stay accountable to these plans?**

Resources

- National
- Community Preventive Services Task Force
- CDC Everything you wanted to know
- APHA CHW Caucuses
- Million Hearts CHW Information
- Policy – State Laws/Fact sheets

Public Health Necessity – Scott Eubank
Susan/Joyce – have registry

Deliverable 1- DEVELOP COMMON LOCATION FOR CHW RESOURCES (WORKSHOPS, TRAINED PEOPLE).

Action	**Who**	**By When**
Create listserv of people in this workgroup to keep in touch and share information.		
Get lists of people involved in CHW current initiatives		
Identify resources across the state		
Advertise resources through professional organizations and other dissemination opportunities		
Deliverable 2: Determine What a CHW is in WV	Who	By When

GROUP 2: COMMUNITY PHARMACISTS/PHYSICIANS

Participants:

Abby Haddix
Ashli Cottrell
Barbara Miller
Bruce Adkins

Discussion Leads:	*Flip Chart Notes:*	*Notetaker:*
Krista Capehart	Christine Compton	Julia Schneider

TOPIC AREAS

Million Hearts and CDC Resources
Collaboration/Implementation of Pharmacists' Patient Care Process
How are patients identified/managed?
Payer's role

OVERVIEW

The pharmacy is where the patients are at – at least once a week. Need to link physicians with the pharmacies; how are we doing that. Krista works with pharmacists across the state and can help with making connections and collaborative practice agreements. WISEWOMEN wants to get pharmacists trained to be health coaches and provide services in communities most in need.

DISCUSSION

The WHAT
What are the issues your organization is seeking to address?
What has been successful (strategies and practices)?
What are the key challenges?

Abby Haddix, Davis Medical Center- has an in-house pharmacy that is owned by the Davis Health System. Pharmacists have access to EMR. The out-patient pharmacist is under-utilized. She has a CPA with the medical center but for her to adjust meds without doc approval, she needs a CPA- Krista knows her and will help her to get this through the board. This will increase her capacity. One provider does a lot of INR- this needs to be included in the CPA. They also have health coaches who do chronic care management. Need pharmacists to do comprehensive med review and this has been a challenge.

Barbara Miller, WISEWOMEN- one of the 21 sites. Only lifestyle program, has to be evidence-based. Don't have many providers. It's very comprehensive. Rely on a provider network to do this. CDC PO wants them to work with pharmacists. Hope to better integrate pharmacists. Congress linked this to breast and cervical cancer program so their patients have to be enrolled in that program. Trying to increase screening program. Want to train pharmacists to be health coaches and do HTN self-management program. Reimbursement is $100. As a health coach, they would do cardiovascular risk assessment, documenting it, health coaching- training coming up on Oct 12-13 which includes motivational interviewing. This would not require CPAs. Krista said she could find pharmacists to do this training. Through 1305 and the Pharmacy Association they have been training pharmacists through the CVH Certificate programs so many of them have these skills. Let's start with these pharmacists (about 15-20 and Krista's residents). Need to find pharmacists that have time to do this. For ex- Kroeger has clinical coordinators in all their stores so pharmacists have time to do this type of work. SMBP programs provide information on sodium, self-measurement; they get a monitor. Patient has to agree to come back to get their device calibrated and health coaching. Barbara will find someone from RE LHD to attend Women's Health Day at Davis to provide resources on Oct 21.

Connections made- Abby hasn't even heard of WISEWOMEN before and she has been with her health system for 15 years. Barbara said she can refer patients to Randolph-Elkins Health Dept. Barbara will send Abby information about

community resources that the LHD can provide- they need patient referrals for the SMBP program. Bruce said that Amy Atkins from this LHD is here at this meeting. Abby needs to meet them. Barbara said that she knows that RE LHD refers patients to Davis Med Center. Abby wants to make sure they track if patients attend the training. Barbara will share the referral forms that includes biometrics and notes where they are making progress. How do we facilitate these types of connections between WISEWOMEN, LHDs and other health systems across the state? What is the role of pharmacists in these connections- use pharmacists as extenders in the areas that need pharmacists to make these connections.

Krista- docs don't know what is happening with their patients in the website- how do we ensure feedback back to the docs. Barbara will send the forms they use for every encounter. Adam Bous WVU OSP is the resource for this. He might have some insight on the best electronic method to do this. Davis Med Center has a portal they use with both docs in their system and outside their system. Challenge will be with pharmacies getting referrals from various places.

Krista will work on a uniform method of electronic documentation for bi-directional communications between pharmacists and docs.

What would success look like for this work?
What objectives do we seek to accomplish?

For WISEWOMEN- have a pharmacist in place by January 1 in 4 of their most needed areas: Mingo, Mercer, McDowell, Parkersburg, Huntington, Lincoln Counties. Women really need access to these services especially in these areas.

For DOH, success would be to have regions covered. Pharmacists and other extenders like PAs to be trained. Funding will be a challenge especially since federal funding is decreasing/being eliminated. How do we sustain this work beyond funding. Need to keep the work and collaboration going. Need to do town halls to see what the community needs. WISEWOMEN has been doing this. You can't wait for the government to do this for us- the communities need to work through their coalitions that address these issues-STPs- same 2 people!

Advocacy/Policy: Need to get healthcare workers involved in policy and advocacy- the legislator is very challenging right now. Heart Day is scheduled for February. Pharmacists Association has advocacy day Feb 3- students will be focusing on heart health and cardiovascular health. Legislative collaborative among the pharmacy schools has been developed. They have been training them for the advocacy day. Bruce offered to come- he is working on Social Determinant of Health, supporting LGBT.

The HOW
How do we accomplish this? What specific actions or tasks need to be carried out in order to complete each step?
Who can we increase awareness of existing or new resources?
How do we want to stay accountable to these plans?

Focus on collaboration and making connections between health systems, pharmacists, LHDs and WISEWOMEN
Collaborate on advocacy/lobby days
Support pharmacy integration/training and Krista's reach across the state with pharmacists and pharmacy students

Next steps- Krista will send an email once the map has been developed. And after the trainings and health fair, they will hold a call in the Fall.

Deliverable 1: Focus on collaboration and making connections between health systems, pharmacists, LHDs and WISEWOMEN

Action	Who	By When
Map provider areas that WISEWOMEN needs pharmacists in to assist with their lifestyle program diabetes, HTN.	Krista, Barbara, Tim (epidemiologist)	September 1
Identify pharmacists in those communities that have the certificate or are interested in getting the additional training	Krista	September 23 for Krista's training; Oct 12-13 for WISEWOMEN training; January 1 to have pharmacists in 4 most needed areas
Hold Trainings	Krista, Barbara	Sept 23; Oct 12-13
Deliverable 2: Support pharmacy integration/training and Krista's reach across the state with pharmacists and pharmacy students		
Davis Med Center to connect with Randolph-Elkins LHD. Identify someone from R-E to attend Women's Health Day at Davis.	Abby, Barbara	October 21
Obtaining CPA for pharmacist at Davis Med Center	Abby, Krista	TBD
Deliverable 3: Electronic documentation for bi-directional communications between pharmacists and docs.	Krista	Long - term

GROUP 3: HYPERTENSION CONTROL

Participants:

Mitzi Beckett
Deborah Carpenter
Dan Christy
Erikah DeFrenh
Jeri Webb
Julia Williams

Discussion Leads:	*Flip Chart Notes:*	*Notetaker:*
Debbie Hennen Julie Williams	Tim Lewis	Robin Rinker

TOPIC AREAS

Blood pressure protocols/electronic health record algorithms
Self-management/PFE
Obtaining accurate blood pressure
Payer's role

OVERVIEW

DISCUSSION

The WHAT

What are the issues your organization is seeking to address?
What has been successful (strategies and practices)?
What are the key challenges?

What is controls? Consistent health within guidelines. <140/90

- Follow HTN Protocols
- Teaching self-management
  - Balance between getting data, but not inundating physicians with data

What is everyone doing?

- Patient family engagement toolkit
- SMBP
- Secondary stroke prevention/outreach program for children to prevent HTN
- Awareness campaign for undiagnosed
- Check.Change.Control. in worksites
  - Worksite wellness
- Community program led by RN—BP, sugar, cholesterol once per week

Main audiences

- Community and worksite
- Common goal=get everyone more involved with their own care

What would success look like for this work?
What objectives do we seek to accomplish?

- Using EHRs that flag BP as abnormal
  - Many places don't, that's where a protocol would come in
- Still room for improvement about correctly taking BP
  - Patients being their own advocate for how to correctly take BP, look beyond the number
  - Issues with automated cuffs—are they serviced? Calibrated? Do people bring home monitors in to test again equipment in health center
  - There is an opportunity to collaborate with pharmacists—help people select home monitors
    - Promote Collaborative Practice Agreements
  - Social workers as part of the team for payment
    - Educate and clarify about prices for meds on or off insurance, because it differs—sometimes lower without insurance
- WVHCA Healthcare Symposium and Fall Retreat next month will include pharmacists and talk about some of these issues. ACTION: send invitation to attendees
- Cost of medication is a large barrier for medication adherence
  - FQHCs help patients find best prices through their clinical pharmacies with 340B pricing, can others help do this?
  - Need for more clinical pharmacists
- What is the payer's role?
  - Setting up pay for performance

- Can charge and get reimbursed for care coordination—there is a need to educate about this opportunity in practices.
- Large learning curve for billing staff
- Need to educate on how to code for HTN so we can get patient's risk levels correct
  - We probably have more patients with HTN than we know because it's not being coded correctly
  - Reconcile charts, teach staff and drs doing chart reviews to keep diagnoses up to date

- Open lines of communication among this group
  - Important to share learning
  - So many resources but do we know where to get those resources?
  - What do we need?
  - Can we create a common library, community of practice?
  - Is there a way to create a community of practice?
    - Like the Appalachian Stroke Network
      - Can we add something to this?
      - OHSR is working on a workshop wizard/database—potential resource?

The HOW

How do we accomplish this? What specific actions or tasks need to be carried out in order to complete each step?
Who can we increase awareness of existing or new resources?
How do we want to stay accountable to these plans?

- Debbie will send resources and videos around to group and will follow up in 1 month and share what others are doing—start a community of practice.
- Start a listserv to continually share resources
- Potentially volunteer with Mitzi's elementary education
- Work together to promote treatment protocols
  - Using the right size cuffs
  - Have nurses recheck with manual

Deliverable -
Assessment of available resources, current workforce needs, and payer coverage—all related to hypertension control.

Action	Who	By When
Send resources and videos around to group and will follow up in 1 month and share what others are doing—start a community of practice.	Debbie	
Start a listserv to continually share resources		
Potentially volunteer with Mitzi's elementary education		
Work together to promote treatment protocols		

GROUP 4: MEDICATION ADHERENCE/MEDICATION SAFETY

Participants:

Katie Cunningham	Kara Garten
Juanita Dempsey	Shawna Long
Jenny Edwards	Dee Ann Price
Jodi Fertig	Mark Stephens

Discussion Leads:	*Flip Chart Notes:*	*Notetaker:*
Stephanie Moore	John Clymer	Mary Jo Garofoli
Cynthia Keeley		

TOPIC AREAS

Patient and family Role
Education/engagement
Data sources
Payer's role

OVERVIEW

DISCUSSION

The WHAT
What are the issues your organization is seeking to address?
What has been successful (strategies and practices)?
What are the key challenges?

- Where want to end up?
  - Acute care transitions
    - Jumbles
    - Care team -speaking same speak
  - Accurate transition
  - Medication lists are not correct
- Accurate care lists
  - Either not taking
  - Medication subbed out
  - EHR issue – cumbersome
- Patient Caregiver
  - Bring up to date list would be helpful
    - Tried patient cards – then not have at next visit
  - Prep/educate patient about updated medication list
- In hospital – cardiologist writes script for meds; hospital list changes meds at discharge?
  - Need to incorporate pharmacy data into EHRs, Clinics, etc.
- How else to have access to data?
  - Pharma by mail?
    - How to track?
      - Express scripts can be imported into EHR
  - Educate patient that they need to be in charge – not docs
    - Patient Center Medical Home
      - Where do we fit in the wheel?

- PC or specialist
  - What info are they getting?
- WV Medicaid implementing Health Home
  - Eg: Manager new to program had 80 different prescriptions – after entry down to 12 scripts
  - Any provider can be a 'health home'
    - More intimate than Case Manager
  - Successes
    - BP's dropping
      - Cared for
      - Being helped
  - WV Medicaid
    - Dr. Jim Becker
      - Medical Director
    - Richard Ernest
      - Program Manager
  - Origin – CMS
    - Must have ICD diagnosis of bi-polar ad
    - Diagnosis/at risk of Hep C
      - Can be enrolled and be helped
  - 2nd Health Home
    - Includes pre-diabetes
    - At risk of obesity
    - Depression
  - www.dhhr.wv.gov Health Homes

What do we choose to focus on?
What would success look like for this work?
What objectives do we seek to accomplish?

- What are we trying to do?
  - Change medications – how information is being communicated
  - Meds prescribed – monitored for what they need
    - Eliminate medical dangers
    - Eliminate drug interactions
    - Care coordinators do not replace primary
- How can we help patients on a med list?
  - Problem = too many
  - Care centers
    - PCP
    - Doc in a box
    - ER
    - Specialists
  - Greenway Prime Suites connects to e-scripts
    - Not 100%
    - Admission records are not 100%
- Show videos in waiting rooms?
- Education is key
- Patients don't share all the meds they're taking
  - May be borrowing meds from spouses
- Select primary pharmacy
  - Have insurance only pay for that pharmacy for scripts

- Flag meds with insurance companies
    - X number of meds
    - Main insurers
    - Chronic conditions
- Meds to Beds
    - Discharging with meds from out-patient pharmacy
    - Too much info at once
    - Too much medical jargon
        - Barriers – not patient's regular pharmacy
- Can pharmacy be paid for script management?
- Pharmacy based patient education
- Bundle with immediate education that currently receive like side effects
- Prior mandatory medical education for standard drugs
    - Not all have proper personnel to handle this
    - Health literacy best practices
- QI – community para-medicine webinar – statewide
    - 8/24 at 2 PM (information shared with attendees/registrants)

The HOW
How do we accomplish this? What specific actions or tasks need to be carried out in order to complete each step?
Who can we increase awareness of existing or new resources?
How do we want to stay accountable to these plans?

- Grant Memorial pulls data information from pharmacy org direct to hospital
    - Clinic uses Greenway
    - Wallet cards – simple to do
- Consistent messaging on adherences
    - One pager
- QI med base and list
- Work with Board of Pharmacy
    - Christa C is president
    - Task force creation
- Standardize med safety list
- Medicaid – Vicky Cunningham/pharmacy head

DELIVERABLE -
Assessment of available resources, current workforce needs, and payer coverage—all related to hypertension control.

Action	**Who**	**By When**
Grant Memorial pulls data inform pharmacy organization direct to hospital		
One pager on consistent messaging on adherences		
QI med base and list		
Work with Board of Pharmacy • Task force creation	Christa C is president	
Standardize medication safety list		
Work with Medicaid	Vicky Cunningham/pharmacy head	

GROUP 5: TEAM-BASED CARE

Participants:

Tiffany Avril	Keaton Hughes
Samantha Batdorf	Melissa Raynes
Susie Fullerton	Angela Schaffer
Patricia Holden	Mike Talley

Discussion Leads:	*Flip Chart Notes:*	*Notetaker:*
Jessica Wright	Miriam Patanian	April Wallace
Carla Van Wyck		

TOPIC AREAS

- Identifying team members. Who's missing?
- Role of Community Health Workers
- Communication / Gaps
- Protocols informal? Formal?
- Payer's role?

OVERVIEW:

What is team-based care?
Consists of everyone who touches the patient, as well as the community that surrounds the patient
More innovation about who to bring into the team.

Definition- *Team-based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient— to accomplish shared goals within and across settings to achieve coordinated, high-quality care.*
https://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-Values.pdf

DISCUSSION

The WHAT
What are the issues your organization is seeking to address?
What has been successful (strategies and practices)?
What are the key challenges?

Chest pain coordinator – we focus on STEMI

- Truly a team effort – whole spectrum of care
  - Community
  - Ems
  - Emergency Room
  - Team
  - Cardiac rehab

Population health nurse manager

- Set up new workflows
- Goals now
  - Health navigator
  - Wellness nurse
  - Getting out to the community
    - Healthy Homes (Medicare/Medicaid population)
    - Local public health units
  - They plan to work with an FNP to do home visits for those that don't have the transportation to get where they need to go.

EMS

- Community paramedicine pilot project established through legislatively mandated process
  - Four EMS agencies are engaged in this project currently
    - 1 agency is working with the hospital to prevent hospital readmits
  - Community paramedics go into the home to focus on social determinants of health
  - Currently there is no reimbursement for this work
    - Quality Insights is working with them to try to show ROI so that this program can be expanded.

What do we choose to focus on?
What would success look like for this work?
What objectives do we seek to accomplish?

Let's get providers to know who their medical and community-based partners are. Person-centered care requires that we keep the team composition flexible.

How can we align better? Many organizations are duplicating services.

- DOH has done this for diabetes – chart that will go into a data system.
  - It identifies where the community resources exist
- Could we duplicate this for cardiac?? Absolutely!
- Linking community services to the medical community and sharing these resources
- How can we tie in cardiac rehab?
- Local health departments are great identifiers of community resources
  - United Way – these
  - American Red Cross
  - Area agencies on aging
  - Family resources network

Need to spread the workload across the team to become more efficient.

Patient access center – 3 nurses to do prior authority for meds, prior authority for care, task box. This freed up the other nurses who were involved in the direct patient care.

STEMI system of care –

- Very established process, so if something doesn't go right, they look at each step along the system to see where they can improve.

Stroke System of Care –

- Very established process.

Challenges –

- How to meet care needs in the most rural areas
- Behavioral health

Payers on board

Flowchart everything

- STEMI and stroke folks have done this – what can we learn
- There isn't a team-based care protocol

The HOW
How do we accomplish this? What specific actions or tasks need to be carried out in order to complete each step?
Who can we increase awareness of existing or new resources?
How do we want to stay accountable to these plans?

Apply what we've learned from Incident Command System – way for everyone to know who is in charge, who does what. It helped to have that sort of organizational approach- that way everyone can see the role they play in the team-based approach (ophthalmologist needs to send the eye exam results to the primary care practitioner)

Flowcharting everything- everyone is clear on what happens every step of the way, you can see where the gaps are, how to improve.

Keep it Simple and Stupid
Don't make systems too complicated
Pool resources to prevent duplication in services

Whatever we decide to do, we need to have payers at the table

Deliverable 1 – Develop flowchart for primary care

Action	**Who**	**By When**
Identify existing team-based protocols, particularly for rural areas	Mike	August 28
Workgroup to review the compiled protocols	Quality Insights	September 30
Bring in other partners (nurse, office manager, WV Office Manager Association, payers), state medical association, WV Primary Care Association, WV Rural Health Association, WV Pharmacy Association	Workgroup to send ideas to Quality Insights (Sam and Carla)	September 15
Intermediate review– Send out to external partners and begin conversations with payers	Workgroup	November 1
Finalize the flowchart	Workgroup	December 15
Develop communication and spread strategy to encourage adoption of the flowchart	Workgroup	December 15

Deliverable 2: Identify Resources Available Throughout the State		
Action	**Who**	**By When**
Look at the type of services that are available – food services, come up with a list of groups that address these service types – could be based from the flowchart. Identify the gaps identified from the flowchart. Pooling like resources – identify 1 person that will hold this information, make it searchable, categorize Identify how to maintain this list – utilize existing groups' resource list, identify types of resources	Tiffany - Workgroup convene	Jan 15
Deliverable 3: Pull Payers into this Work		
Action	**Who**	**By When**
Pull together the list of payers and reach out to them with a draft of the flowchart.	Jessica/Carla	November 15

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®.

Partners in Attendance:

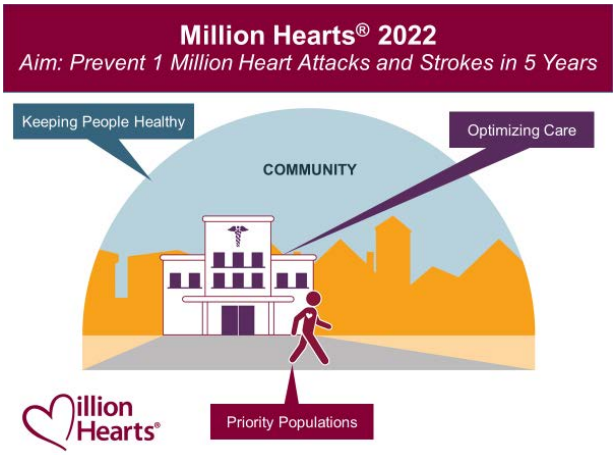
American Heart Association
BPH-OCHSHP
Cabell Huntington hospital
Camden Clark Medical Center
Centers for Disease Control and Prevention
Center for Local Health
Charleston Internal Medicine
Community Care of WV
Davis Medical Center
Division of Health Promotion and Chronic Disease
Grant Memorial Hospital
Health Quality Innovators
Healthy Bodies Healthy Spirits West Virginia
HIMG
Kindred at Home
Mingo Wayne Home Health
Minnie Hamilton Health System
National Association of Chronic Disease Directors
National Forum for Heart Disease & Stroke Prevention
Quality Insights
Roane County Family Health Care
St Mary's Medical Center
Texas A&M University

UniCare Health Plan of WV
West Virginia University Hospital
West Virginia University School of Public Health, Office of Health Services
Wheeling Hospital
WV Bureau for Public Health
WV DHHR/BPH Health Promotion and Chronic Disease
WV Health Statistics Center
WV Medicaid
WV OEMS
WV WISEWOMAN Program
WVBPH/Office of Community Health Systems & Health Promotion
WVRHA
WVSOM Center for Rural and Community Health
WVU School of Pharmacy

Additional Partners:
UMWA Health and Retirement Funds
WV DHHR/WV BMS
DaVita
Thomas Health
Dignity Hospital and Home Health
WV Caring
WVU Medicine

Presentations:

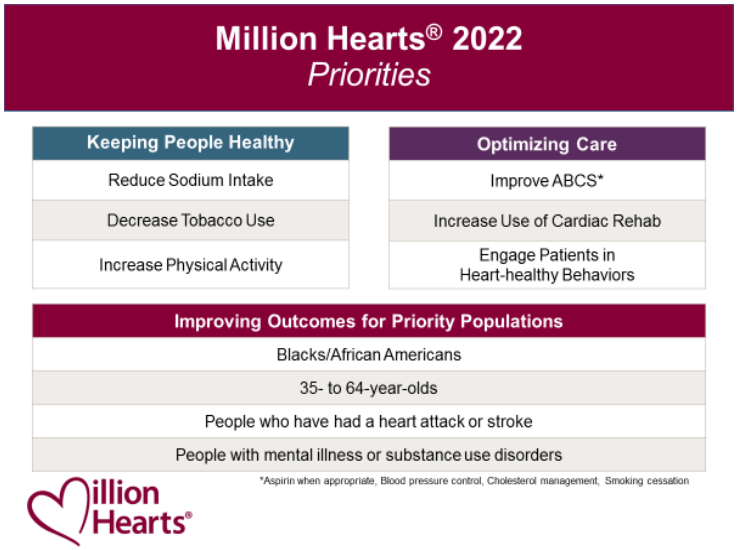
Million Hearts® 2022
Robin Rinker, MPH, CHES
Health Communications Specialist
Division for Heart Disease and Stroke Prevention, CDC



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.

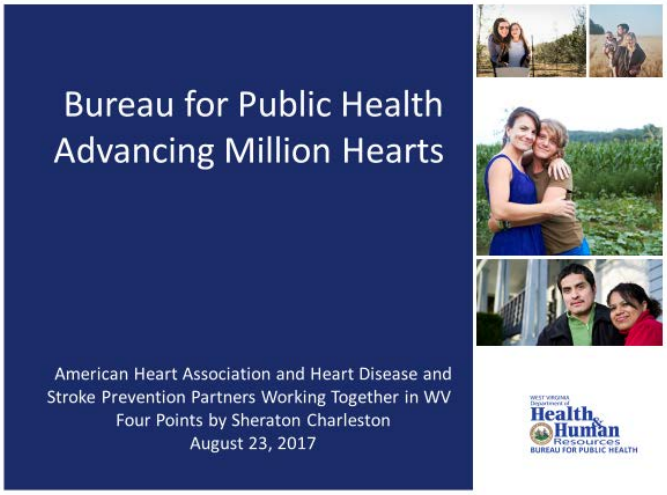
Million Hearts® 2022 is co-led by the Centers for Disease Control & Prevention and the Centers for Medicare and Medicaid Services. But it is carried out by a variety of partners across federal and state agencies, and private organizations. Million Hearts® provides a platform to shine light on a selection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



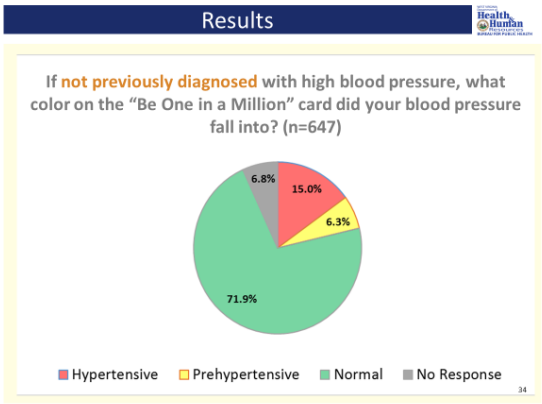
West Virginia Bureau for Public Health Address Priorities that Align with Million Hearts®

Jessica Wright, Director, Health Promotion and Chronic Disease
Melissa Raynes, Director, Office of Emergency Medical Services
Barbara Miller, WISEWOMAN



WVBPH Mission: Advocating for chronic disease management and prevention.
Purpose: To create the systems, practices and environments to facilitate the prevention and management of chronic disease.

Hypertension and Prediabetes Awareness Project: This project is increasing patient awareness of prediabetes and hypertension control in selected local health departments in Randolph County Health Department, Grant County Health Departments and Mineral County Health Department. The goal is to increase awareness, education, referrals, and establishment of a screening algorithm for health departments, and creation of a local health department hypertension/prediabetes awareness model.



Next steps include: Continuing to recruit those who have not participated and encouraging health departments to formally engage with the providers in the county. They are connecting with diabetes prevention programs in the community and supporting the American Heart Association (AHA) – Check Change Control; expanding to other health care providers to utilize these tools and make referrals. They will also conduct an Evaluation Assessment with those who have participated over the last 4 years to identify practice changes, new or revised protocols, increased referrals and lessons learned.

Synergy Project: This project works to enhance the use of electronic health records and provides technical assistance for treating patients with high blood pressure. They are using the Chronic Disease Electronic Management System to identify undiagnosed hypertensive patients in health systems and to assess blood pressure adherence while also promoting practice protocols for team based care and self-management for high blood pressure. Synergy TEAM: HPCD, West Virginia University (WVU) Office of Health Services Research, WVU School of Pharmacy Wigner Institute, West Virginia Academy of Family Physicians, and Quality Insights, Inc. Four focus areas for interventions: Mineral County, Mid- Ohio Valley (six counties), Greenbrier County and Putnam/Kanawha counties.

Office of Emergency Medical Management: Ensures quality pre-hospital and emergency care within a changing environment. They have several initiatives they are working on including a standard EMT Treatment Protocol, medical direction, a proposed stroke rule, and a Stroke Advisory Council.

WISEWOMEN: This program is decreasing the risk of heart disease and stroke in low income women aged 30-64 by reducing cardiovascular risk factors through evidence-based programs that support lifestyle changes. All participants are assessed for tobacco use and secondhand smoke exposure. They partnered with the WV Tobacco Program to bring the Mayo Clinic's Tobacco Treatment Certification Program and have trained 59 Certified Treatment Specialists and over 300 health coaches in WV. They developed a booklet "Take Charge of YOUR Health" that provides information on sodium and trans-fat; partnered with WVU Extension to provide the Eating Healthy, Being Active program. WISEWOMAN is also working in the clinical setting on a hypertension self-management module; cholesterol testing; physical activity; health coaching; blood pressure control; cholesterol management; and smoking cessation.

Quality Insights Address their Work and Alignment with Million Hearts®
Debbie L. Hennen, RN Project Coordinator, Quality Insights

Quality Insights' Quality Innovation Network offers evidence-based resources to improve cardiac health by convening a Learning and Action Network to give healthcare providers, community organizations and patients the opportunity to share, learn, and make a difference. They work with practices on how to improve their numbers on several indicators and comparing themselves to other practices and they are working with physician offices to promote the development of internal BP control protocols. The Home Health Quality Improvement (HHQI) National Campaign provides evidence-based tools and resources for the nation's 13,000 CMS-reporting home health agencies. HHQI created a nationwide Home Health Cardiovascular Data Registry.

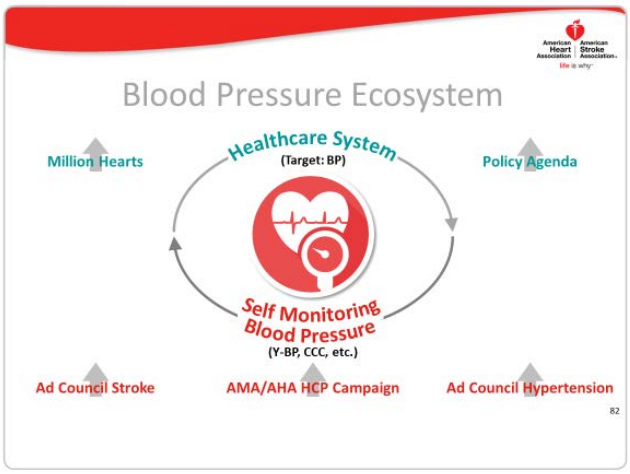
American Heart Association/American Stroke Association Programs and Resources that Align with Million Hearts®
Christine Compton, MPH, Government Relations Director, AHA, Great Rivers Affiliate
Cynthia A. Keely, Director, Mission: Lifeline WV, AHA

The American Heart Association is 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.

There have been several advocacy wins in WV: CPR in schools; shared-use agreements for schools that want to open their facilities for community activities; increased tobacco tax to 65 cents.

Current advocacy priorities include:
Comprehensive smoke-free policies at the local level; preventing pre-emption of existing ordinances; Medicaid coverage of comprehensive smoking cessation services and medications to be provided for little or no cost; access to quality health care that is affordable and accessible by protecting Medicaid expansion enacted by EO in 2013; increase of sugary drink tax to be at least 1 cent per ounce and include a provision that allocates a portion of the funding for research.

Quality and Systems Improvement Priorities: Get with the Guidelines: AFIB, CAD, Heart Failure, Cardiac Resuscitation, Stroke Patient Management Tools. TA includes real-time data collection, point-of-care education materials, integrated decision support, forms, workshops/webinars, AHA QI Field Staff Support, recognition for hospital team achievement, CMS data submission, and performance feedback for continuous QI and cost effectiveness.



Resources:

- Heart Attack Risk Calculator www.cvriskcalculator.com
- AHA's Smoking Cessation Tools and Resources
- Get with the Guidelines www.heart.org/quality
- My Life Check Health Assessment http://www.heart.org/HEARTORG/Conditions/My-Life-Check---Lifes-Simple-7_UCM_471453_Article.jsp#.WYynd4WcE2w
- Check, Change, Control: Blood Pressure http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/HighBloodPressureToolsResources/Find-a-Check-Change-Control-Program-Near-You_UCM_449325_Article.jsp#.WYynnoWcE2w
- Food and Beverage Tool Kit for a healthy food environment and policies http://www.heart.org/HEARTORG/HealthyLiving/WorkplaceHealth/EmployerResources/Healthy-Workplace-Food-and-Beverage-Toolkit_UCM_465195_Article.jsp#.WYynwIWcE2w

Target BP: http://targetbp.org/

- A call to action motivating medical practices, practitioners and health services organizations to prioritize blood pressure control
- Recognition for healthcare providers who attain high levels of blood pressure control in their patient populations, particularly those who achieve 70, 80 percent or higher control
- A source for tools and assets for healthcare providers to use in practice, including the AHA/ACC/ CDC, Hypertension Treatment Algorithm and the AMA's M.A.P. Checklist

Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in West Virginia Pre- Survey Results

Previous Involvement in Million Hearts® activities:
- Yes-43.3%
- No-26.7%
- I don't know-30.0%

Use community health workers for heart disease/stroke in WV:
- Yes-24.1%
  CHW/CHERP Training program; CHWs as extensions of primary care team; Pilot projects led by university; Diabetes self management program
- No-75.9%

Currently work with community pharmacists/physicians for heart disease/stroke in WV:
- Yes-53.6%
  Educational materials and resources for providers; Partner with university; Partner with chronic care clinics; Collaborative practice agreement pilot program
- No-46.4%

Currently work on medication adherence in WV:
- Yes-63.3%
  Patient education; Care coordination; Partner with university; Partner with not-for-profit; Management of opiate prescriptions
- No-36.7%

Currently work on prehypertension in WV:
- Yes-41.4%
  Patient education; Data collection; Electronic health records
- No-58.6%

Currently work on self-management of blood pressure in WV:
- Yes-62.1%
  - Patient education; Self-management goal setting; Individualized patient care Plan; Partner with clinicians and HHAs
- No-37.9%

Currently conduct team-based care for heart disease/stroke in WV:
- Yes-46.7%
  - Healthcare setting; Variety of state partners; Health Homes; Chest pain teams; Stroke council
- No-53.3%

Success at end of the meeting:
Defined priorities for upcoming years; Networking; Resources/info for work; Heart disease/stroke in WV; WV community awareness of heart disease/stroke; More info about Million Hearts® Collaboration; Ability to educate children early; Statewide stroke system

Agenda:

Time	Agenda Item/Topic	Speaker/Facilitator
8:30 – 9:00 am	**Partner Networking**	
9:00	**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
9:05 – 9:40 am	**Introductions** In one sentence, what excites you about your role in heart disease and stroke prevention?	**John Bartkus** **Pensivia**
9:40 – 10:30am	**Million Hearts® 2022** • Million Hearts® Accomplishments • What must happen to prevent? • 2017 Focus **Q and A/Group Interaction**	**Robin Rinker, MPH, CHES** Health Communications Specialist Division for Heart Disease and Stroke Prevention Centers for Disease Control and Prevention
10:30 – 10:45am	**Break**	
10:45 – 11:05am	**West Virginia Bureau for Public Health address priorities that align with Million Hearts®.** **Q and A**	**Jessica G. Wright, RN, MPH, CHES** Director, Health Promotion and Chronic Disease; Melissa Raynes, Director, Office of Emergency Medical Services; Barbara Miller, RN, WISEWOMAN
11:05 – 11:20am	**Quality Insight address their work and alignment with Million Hearts®.** **Q and A** **Group Discussion**	**Debbie L. Hennen, RN** Project Coordinator Quality Insights
11:20 – 11:35am	**AHA/ASA programs and resources that align with Million Hearts** **Q and A**	**Christine Compton,** MPH Government Relations Director American Heart Association Great Rivers Affiliate **Cynthia A. Keely, BA,** RRT, LRTR Director, Mission: Lifeline WV American Heart Association
11:35 am – 12:15pm	**Catered Lunch**	
12:15 – 2:05pm	**Afternoon Breakouts/Facilitated Discussions**	
	Program efforts that align and ways to work together • Community Health Workers • Community Pharmacists/Physicians • Medication Adherence • Self-management of blood pressure • Team Based Care	Session Monitors
2:00 – 2:30pm	**Reports from Breakouts**	John Bartkus
2:30 – 2:50 pm	**Plans for Follow-up/Next Interactions**	John Bartkus
2:50 – 2:55pm	**Evaluation and Feedback Process**	Whitney Garney
2:55p.m.	**Wrap Up**	April Wallace
3:00p.m.	**Adjourn**	

Team-based Care

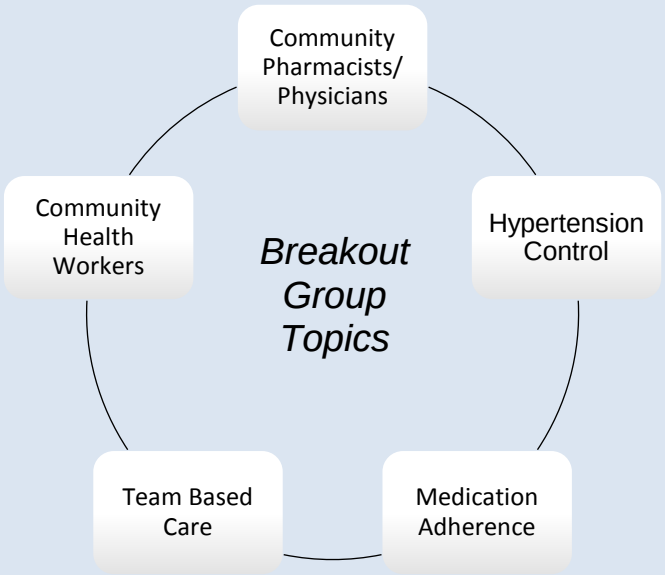
Advancing Million Hearts ®:
American Heart Association and Heart Disease and Stroke Prevention Partners Working Together in West Virginia

August 22, 2017

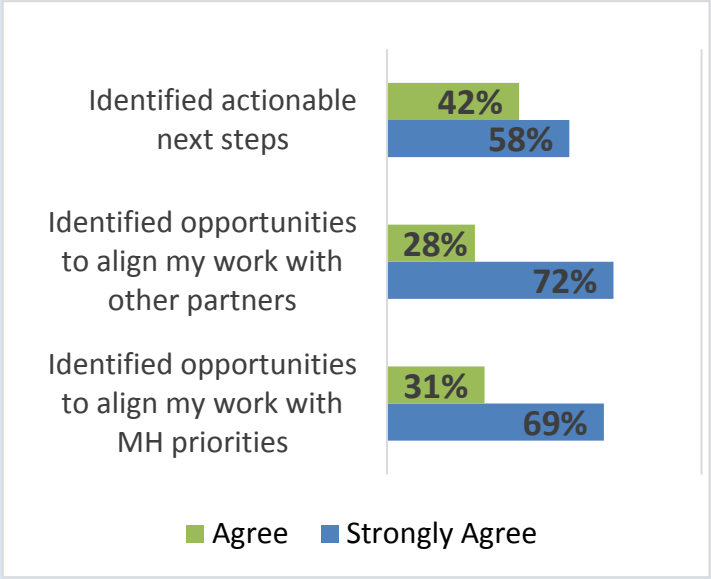
On August 22, 2017, the American Heart Association (AHA) worked with partners to host the Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners Working Together in West Virginia Meeting. The goal of the meeting was for attendees to expand their knowledge of evidence-based programs, collaboration strategies, tools, resources and generate connections to align programs and new initiatives that support Million Hearts® (MH).

62 West Virginia partners attended the meeting representing 51 organizations.

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



Participants felt the meeting allowed them to:



"It was interesting to see how fellow practitioners had a different perspective and path, but we were all focused on the same outcomes…"

-Meeting Participant

Participants felt the most valuable part of the meeting was…

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

Organization name
Presenter's name
Credentials

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

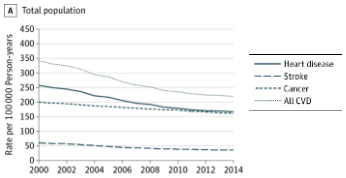
Heart Disease and Stroke in the U.S.

- 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 *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- to 64-year-olds
People who have had a heart attack or stroke
People with mental illness or substance use disorders

*Aspirin 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 • Institute healthy food procurement and nutrition policies
Decrease Tobacco Use Target: 20%	• Enact smoke-free space policies that include e-cigarettes • Use pricing approaches • Conduct mass media campaigns
Increase Physical Activity Target: 20% (Reduction of inactivity)	• Create or enhance access to places for physical activity • Design communities and streets that support physical activity • Develop and promote peer support programs

Optimizing Care

Goals	Effective Health Care Strategies
Improve ABCS* Targets: 80% **Increase Use of Cardiac Rehab** Target: 70% **Engage Patients in Heart-healthy Behaviors** Targets: TBD	***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, and 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

*Aspirin 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 • Increasing physical activity
People who have had a heart attack or stroke	• Increasing cardiac rehab referral and participation • 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**

Our Commitment

- Partner statement of commitment
- Description of intended actions

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

Million Hearts®

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

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

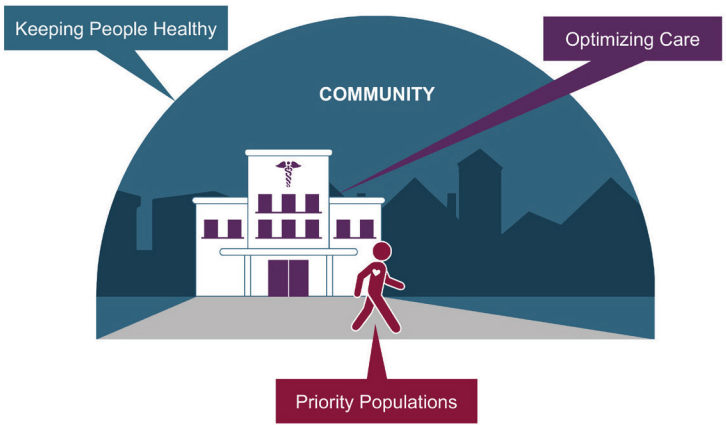
The only way we—as a nation—will meet the Million Hearts® goals is through the collective and focused action of a diverse range of partners.

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.

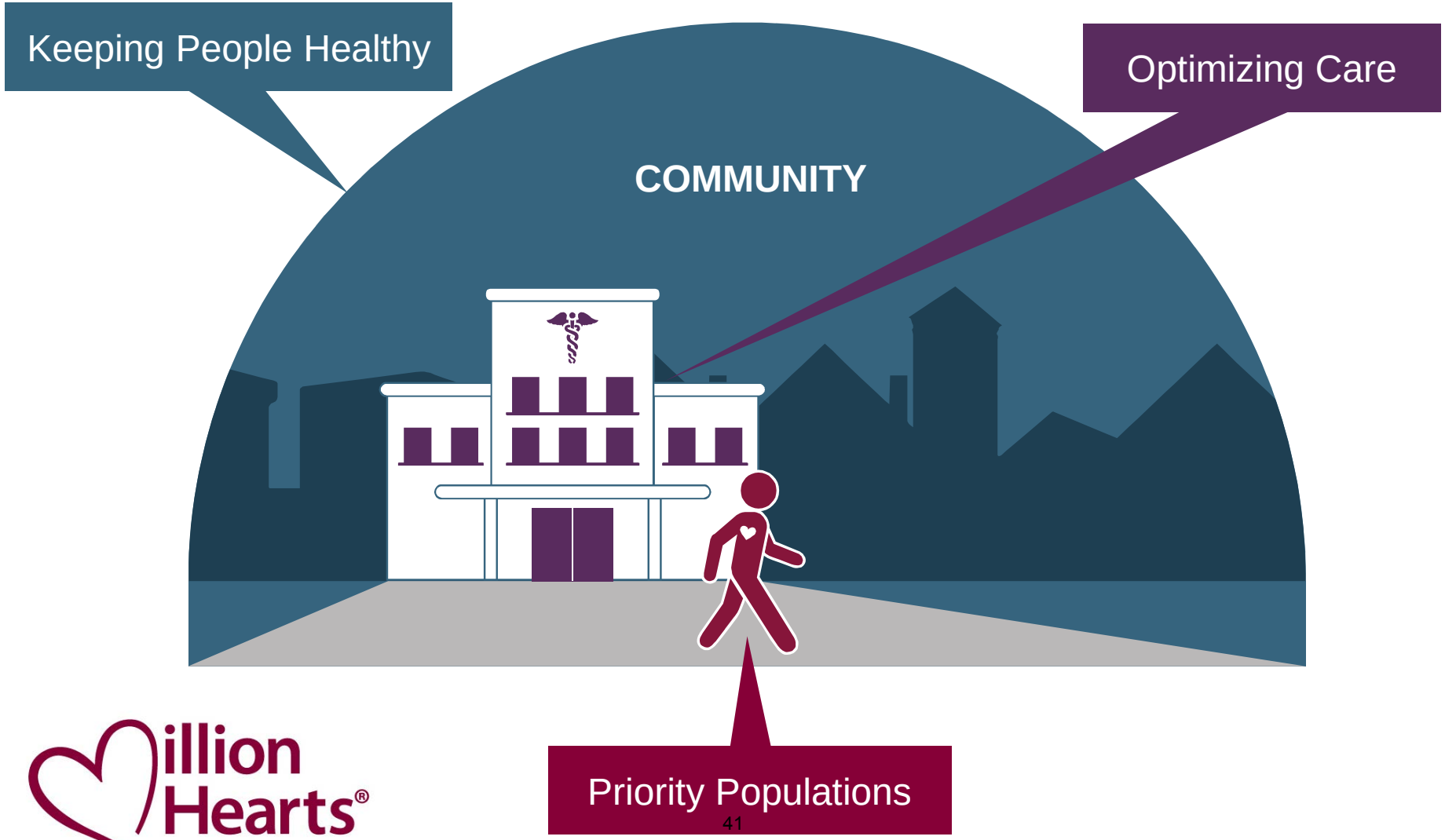
Million Hearts® 2022 Priorities

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.



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 20% Target	• Enhance consumers' options for lower sodium foods • Institute healthy food procurement and nutrition policies
Decrease Tobacco Use 20% Target	• Enact smoke-free space policies that include e-cigarettes • Use pricing approaches • Conduct mass media campaigns
Increase Physical Activity 20% Target (Reduction of inactivity)	• Create or enhance access to places for physical activity • Design communities and streets that support physical activity • 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 • Increasing physical activity
People who have had a heart attack or stroke	• Increasing cardiac rehab referral & participation • 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

West Virginia
2016-2017 Public Policy Agenda

Building healthier lives, free of cardiovascular diseases and stroke.

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 by coronary heart disease and stroke by 20 percent by 2020.

- **Tobacco Free-** Support comprehensive smoke-free polices at the local level. Advocate to prevent pre-emption of exisiting ordinances.
- **Access to Care -** Advocate for Medicaid coverage of comprehensive smoking cessation services and medications to be provided for little or no cost.
- **Healthy Eating -** Update state licensure regulations for child care centers that serve 7-12 children to ensure compliance with recommended nutrition, physical activity and screen time standards.
- **Access to Care -** Assure access to quality health care that is affordable and accessible by protecting Medicaid expansion, enacted by executive order in 2013. **Glide Path Goal**
- **Healthy Eating** – Build momentum for Healthier Food Choices in Public Places policies that would standardize quality and nutrition standards for food and beverage consumption for vending on state property. **Glide Path Goal**
- **Healthy Eating** – Advocate for an increase in the state's sugary drink tax to be at least 1 cent per ounce and include a provision that allocates a portion of the tax for research. **Glide Path Goal**
- **Tobacco Free** – Advocate for an increase in the state's legal tobacco purchasing age from 18 to 21 years old.

Advancing Million Hearts®: AHA and State Heart Disease and Stroke Partners Working Together in West Virginia

August 23, 2017
9:00 AM to 3:00 PM EST

Four Points by Sheraton Charleston
600 Kanawha Boulevard East
Charleston, West Virginia 25301

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

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 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	Welcome and Overview of the day	Julie Harvill & John Clymer
	Introductions	John Bartkus
	Million Hearts® 2022	Robin Rinker
	Programs and Resources that Align with Million Hearts®	
	- West Virginia Bureau for Public Health	Jessica Wright
	- Office of Emergency Medical Services	Melissa Raynes
	- West Virginia WISEWOMAN	Barbara Miller
	- Quality Insight	Debbie L. Hennen
	- AHA/ASA	Christine Compton & Cynthia Keely
11:30 AM	Lunch	
12:15 PM	Afternoon Breakouts – Workgroups	
2:10 PM	Workgroup Report-outs	John Bartkus
2:50 PM	Evaluation and Feedback	Whitney Garney
3:00 PM	Wrap up / adjourn	April Wallace

Expectations - Approach for the Day

John Bartkus, PMP, CPF
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 Workgroups

1 Community Health Workers	2 Community Pharmacists / Physicians	3 Hypertension Control	4 Medication Adherence	5 Team Based Care
Adam Baus **Scott Eubank** Whitney Garney Julie Harvill	**Krista Capehart** Christine Compton Julia Schneider	**Debbie Hennen** **Julie Williams** Tim Lewis Robin Rinker	**Stephanie Moore** **Cynthia Keeley** John Clymer Mary Jo Garofoli	**Jessica Wright,** **Carla Van Wyck** Miriam Patanian April Wallace

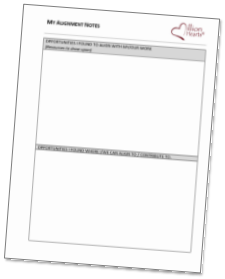
ACTION: Before lunch is over, please add your name to the Flip-chart for the Workgroup you plan to attend/engage.

Million Hearts®

A key focus for the day…

ALIGNMENT

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

Million Hearts®

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]

Million Hearts®

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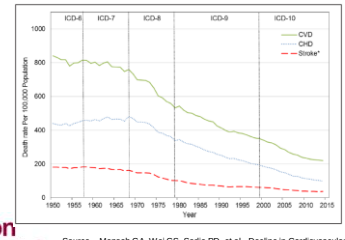
2. Kochanek KD, Arias E, Anderson RN. How did cause of death contribute to racial differences in life expectancy in the United States in 2010? NCHS data brief, no 125. Hyattsville, MD: National Center for Health Statistics. 2013

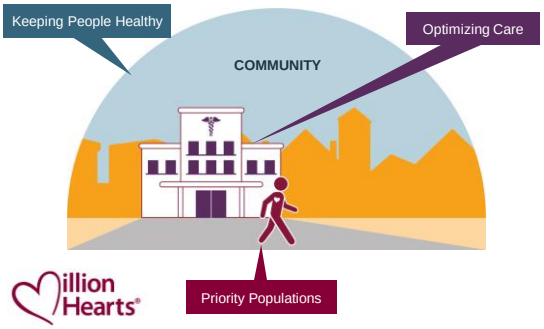
Heart Disease and Stroke Trends 1950-2015

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 • Institute healthy food procurement and nutrition policies
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Optimizing Care

Goals	Effective Health Care Strategies
Improve ABCS* Targets: 80% **Increase Use of Cardiac Rehab** Target: 70% **Engage Patients in Heart-healthy Behaviors** Targets: TBD	***High Performers Excel in the Use of…*** • **Teams**—including pharmacists, nurses, community health workers, and cardiac rehab professionals • **Technology**—decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care • **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

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

Million Hearts® Hypertension Champion in West Virginia

2014: Roane County Family Health Care, Spencer, WV

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

Million Hearts®

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

Million Hearts®

Q & A

Group Interaction

Million Hearts®

Break

Resume at 10:45

WEST VIRGINIA BUREAU FOR PUBLIC HEALTH PROGRAMS AND RESOURCES THAT ALIGN WITH MILLION HEARTS®

Jessica G. Wright, RN, MPH, CHES
Director, Health Promotion and Chronic Disease

Melissa Raynes
Director, Office of Emergency Medical Services

Barbara Miller, RN
WISEWOMAN

Bureau for Public Health Advancing Million Hearts

American Heart Association and Heart Disease and Stroke Prevention Partners Working Together in WV
Four Points by Sheraton Charleston
August 23, 2017

Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Million Hearts

Updates from:

- West Virginia Department of Health and Human Resources (DHHR), Bureau for Public Health (BPH), Division of Health Promotion and Chronic Disease (HPCD)
- DHHR, BPH, Office of Emergency Medical Services
- WISEWOMAN

Review:

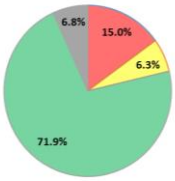
- Division's mission, purpose and goals
- Hypertension and Prediabetes Awareness Project
- Synergy Project
- Team Based Care
- WV Well@Work campaign

- **Mission:** Advocating for chronic disease management and prevention
- **Purpose:** To create the systems, practices and environments to facilitate the prevention and management of chronic disease
- **Goals:**
  - Reduce obesity
  - Improve key chronic disease health indicators

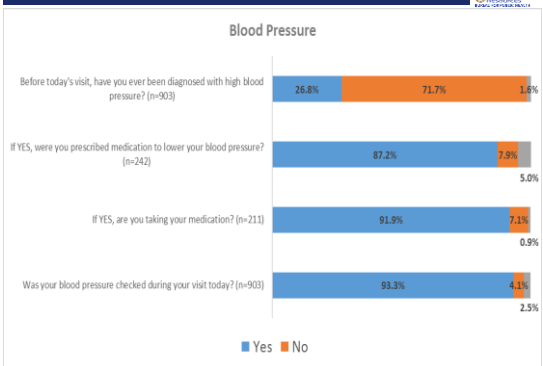
Project Background

- **Purpose:** Increase patient awareness of prediabetes and hypertension in selected local health departments
- **Tools:** Centers for Disease Control and Prevention (CDC) Prediabetes Screening Test; Million Hearts Blood Pressure Stoplight Card; patient survey and prediabetes self-care booklet
- **Locations:** Randolph County Health Department, Grant County Health Department and Mineral County Health Department
- **Duration:** 1-3 months
- **Goals:** Awareness, education, referrals, establishment of a screening algorithm for health departments, and creation of a local health department hypertension/prediabetes awareness model

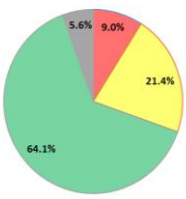
If **not previously diagnosed** with high blood pressure, what color on the "Be One in a Million" card did your blood pressure fall into? (n=647)



Hypertensive | Prehypertensive | Normal | No Response



If blood pressure was checked, what color on the 'Be One in a Million' card did your blood pressure fall into? (n=880)



Hypertensive | Prehypertensive | Normal | No Response

Hypertension & Pre-diabetes Awareness Project

What's next:

- Continue to recruit those who have not participated
- Continue to encourage health departments to formally engage with the providers in the county
- Encourage connecting with diabetes prevention programs in the community or beginning one in the health department
- Support the American Heart Association (AHA) – *Check Change Control*
- Expand to other health care providers to utilize tools and make referrals
- Conduct Evaluation Assessment with those who have participated over the last 4 years to identify practice changes, new or revised protocols, increased referrals and lessons learned

Synergy Project

- **Synergy TEAM: HPCD, West Virginia University (WVU) Office of Health Services Research, WVU School of Pharmacy Wigner Institute, West Virginia Academy of Family Physicians, and Quality Insights, Inc.**
  - Four focus areas for interventions: Mineral County, Mid-Ohio Valley (six counties), Greenbrier County and Putnam/Kanawha counties
  - Enhancing EHR usage and providing t/a for treating patients with high blood pressure
  - Utilize the Chronic Disease Electronic Management System (CDEMS) to identify undiagnosed hypertensive patients in health systems & assess blood pressure adherence
  - Promote practice protocols for team based care
  - Protocols for self management for high blood pressure

Team Based Care

- 129 providers in Kanawha and Putnam counties received education modules specific for hypertension: medication adherence; self-management plans; high blood pressure control; team based care (Quality Insights partnership)
- 10 pharmacists trained in the American Pharmacists Association (APhA) Pharmacy-Based Cardiovascular Disease Certificate Program (WVU Sch of Pharmacy Wigner Institute)
- Pharmacy Collaborative Practice Agreements
  - Training conducted August 18, 2017
  - Approximately 80 participants
  - Follow up for technical assistance
- Medicaid Health Home (diabetes, pre-diabetes, obesity, anxiety, depression)

Well@Work WV

- Working with 84 worksites to assess health needs
  - Develop a plan
  - Utilize AHA resources:
    - *Check, Change, Control*
    - Food and Beverage Tool Kit
  - American Diabetes Association – Stop Diabetes@Work
  - National Diabetes Prevention Program
- 56 worksites have food service policies that include sodium reduction
- 243 visits to sodium reduction worksite page
- HPCD implementing *Check, Change, Control* as a staff activity

Collaboration with Tobacco Prevention

HPCD also supports tobacco prevention initiatives including:

- Cessation
- Clean Indoor Air
- Youth Prevention

Contact

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West Virginia Department of Health and Human Resources
Bureau for Public Health
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www.chronicdisease.org

Office of Emergency Medical Services

Office of Emergency Medical Services

Mission: Ensure quality pre-hospital and emergency care within a changing environment

STEMI Initiatives:

Definition: ST-Elevation Myocardial Infarction (STEMI) is a very serious type of heart attack during which one of the heart's major arteries (one of the arteries that supplies oxygen and nutrient-rich blood to the heart muscle) is blocked. ST-segment elevation is an abnormality detected on the 12-lead ECG

Stroke Initiatives: Protocols, medical direction, proposed stroke rule, Stroke Advisory Council

Cardiac Arrests

2014 = 2,981

2015 = 3,514

2016 = 3,675

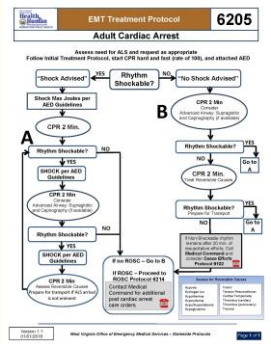
Primary Provider Impression

	2016	2014	2015
427.50 – Cardiac Arrest	3,335	2,727	3,137
427.90 – Cardiac Rhythm Disturbance	5,044	4,419	5,237
786.50 – Chest Pain/Discomfort	24,024	21,958	24,131

Secondary Provider Impression

	2016	2014	2015
427.50 – Cardiac Arrest	413	310	470
427.90 – Cardiac Rhythm Disturbance	2,075	1,425	2,111
786.50 – Chest Pain/Discomfort	3,716	2,985	3,962

EMT Treatment Protocol



Contacts

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West Virginia WISEWOMAN
Barbara Miller, RN
WVU School of Nursing/WISEWOMAN

Mission

- Decrease risk of heart disease and stroke in low income women aged 30-64 by reducing cardiovascular risk factors through lifestyle changes
- Utilize evidence based programs that support lifestyle changes

Aligning with Million Hearts

WISEWOMAN

- Each provider site has at least 1 Certified Tobacco Specialist on site

Million Hearts Target

- Changing the environment
- Reduce smoking

Continued

WISEWOMAN

- All participants are assessed for tobacco use and secondhand exposure
- Referrals for cessation are tracked
- Reimburse for CTT's time

Million Hearts Target

- Reduce smoking

Continued

WISEWOMAN

- Utilize health coaching
- Developed a booklet "**Take Charge of YOUR Health"** that provides information regarding sodium and fats
- Partner with WVU Extension to provide the **Eating Healthy, Being Active** program

Million Hearts Target

- Changing environments
- Reduce sodium
- Eliminate trans fats

Optimizing Care in the Clinical Setting

- Hypertension Self-Management Module
- Pay for cholesterol testing
- Pay for TOPS
- Encourage physical activity
- Ongoing health coaching
- Blood Pressure Control
- Cholesterol Management
- Smoking Cessation Treatment

Addressing Tobacco Use in a BIG Way

- WV WISEWOMAN partnered with the WV Tobacco Program to bring the Mayo Clinic's Tobacco Treatment Certification Program to West Virginia twice. A total of 59 Certified Treatment Specialists (CTTS) completed the program

Contact Information

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- Robin Seabury 304-356-4415 Robin.A.Seabury@wv.gov
- Barbara Miller 304-356-4447 Barbara.M.Miller@wv.gov

Million Hearts®

Q & A

Group Interaction

QUALITY INSIGHT WORK AND ALIGNMENT WITH MILLION HEARTS®

Debbie L. Hennen, RN
Project Coordinator, Quality Insights

Improving Cardiac Health & Reducing Cardiac Healthcare Disparities

An Overview

DEBBIE HENNEN, RN
WV Project Coordinator

Quality Improvement Organizations | Quality Insights

How Can We Help

- Quality Insights' Quality Innovation Network offers a wealth of free evidence-based resources to improve cardiac health.
- We also convene Learning and Action Networks (LANS) to give healthcare providers, community organizations and patients the opportunity to share, learn and make a difference.
- Our efforts align with the Million Hearts® initiative that seeks to prevent one million heart attacks and strokes.

Collaboration with Million Hearts®

- Quality Insights works closely with Million Hearts® to engage clinicians and beneficiaries to improve cardiac health. Through this relationship, Dr. Janet Wright has recorded four webinars specifically for our QIN:
  - Million Hearts® Overview
  - Million Hearts®: Hypertension Protocols
  - Million Hearts® 2022: Getting to a Million is Possible
  - Million Hearts® and Cardiac Rehab: Saving Lives, Restoring Health

Million Hearts®, Quality Insights & MIPS

- Improvement Activities
  - IA_PM_5: Population Management - *Data Reporting/Benchmarking*
  - IA_PM_6: Population Management - *PFE Cardiac Toolkit*
- Quality
  - 236 - Controlling High Blood Pressure
  - 204 - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet
  - 226 - Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention *(topped out for claims reporting)*
  - 318b - Cholesterol Fasting (LDL-C) Test Performed AND Risk-Stratified Fasting LDL-C
- Advancing Care Information
  - Patient-Generated Health Data - *Advancing Care Information Objectives & Measures*

Promoting Blood Pressure Control Protocol

- Working with physician offices to promote the development of internal blood pressure (BP) control protocols
  - Accurate BP readings – *7 Simple Tips To get an Accurate BP Reading*
  - Million Hearts® BP Protocol template
  - PDSA BP Control
  - PDSA Smoking Cessation

Home Health and Million Hearts®

- The Home Health Quality Improvement (HHQI) National Campaign provides evidence-based tools and resources for the nation's 13,000+ CMS-reporting home health agencies.
- This initiative intentionally aligns with Million Hearts'® goals of preventing heart attacks and strokes and includes National Quality Forum (NQF) / Physician Quality Reporting System (PQRS) ABCS Measures.
- HHQI created a nationwide Home Health Cardiovascular Data Registry (HHCDR).

Contact Us

- Practices with **15 or fewer** clinicians:
  - Email qpp-surs@qualityinsights.org
- Practices with **16 or more** clinicians:
  - Email dhennen@qualityinsights.org

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

Quality Insights

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization for West Virginia, Pennsylvania, Delaware, New Jersey and Louisiana 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. Publication number QI-81-WV-081017

Million Hearts®

Q & A

AHA/ASA PROGRAMS AND RESOURCES THAT ALIGN WITH MILLION HEARTS®

Christine Compton, MPH
Government Relations Director
American Heart Association, Great Rivers Affiliate

Cynthia A. Keely, BA, RRT, LRTR
Director, Mission: Lifeline WV
American Heart Association

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

Christine Compton, MPH
Government Relations Director for West Virginia
Cynthia Keely, BA, RRT
Director Quality and Systems Improvement

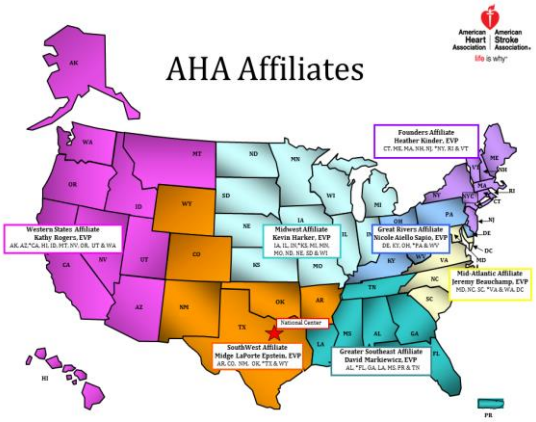
American Heart Association | American Stroke Association
life is why

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%.



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 West Virginia

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 WV Advocacy Committee**
  Grassroots advocacy network and statewide advocates

AHA and Million Hearts® Spotlight on West Virginia

Advocacy Priorities

- **Tobacco Free**- Support comprehensive smoke-free polices at the local level. Advocate to prevent pre-emption of exisiting ordinances.
- **Access to Care** - Advocate for Medicaid coverage of comprehensive smoking cessation services and medications to be provided for little or no cost.
- **Access to Care** - Assure access to quality health care that is affordable and accessible by protecting Medicaid expansion, enacted by executive order in 2013.
- **Healthy Eating** – Advocate for an increase in the state's sugary drink tax to be at least 1 cent per ounce and include a provision that allocates a portion of the tax for research.

Tobacco-Free

- Reduce tobacco use in West Virginia
- Increasing price of tobacco products – 2016
- Defending our smoke-free protections
- Working to ensure the US Food and Drug Administration has the authority to regulate tobacco, including e-cigarettes

AHA and Million Hearts® Spotlight on West Virginia

Quality & Systems Improvement

Get With The Guidelines & Mission: Lifeline

When medical professionals apply the most up-to-date evidence-based treatment guidelines, **patient outcomes improve**.

AHA and Million Hearts® Spotlight on West Virginia

Quality & Systems Improvement Priorities

Get With The Guidelines: AFIB, CAD, HF, Resus, Stroke

Patient Management Tools (PMT)

- Real-time data collection
- Point-of-care education materials
- Integrated decision support
- Arrival, discharge, and follow-up care forms
- Professional education opportunities – workshops/webinars
- Education
- AHA Quality Improvement Field Staff Support
- Recognition – national/local for hospital team achievement
- Center for Medicare and Medicaid (CMS) data submission*
- Performance feedback reporting for continuous QI
- Cost Effectiveness

AHA and Million Hearts® Spotlight on West Virginia

Quality & Systems Improvement Priorities

Get With The Guidelines & Mission: Lifeline Quality Awards

- Cabell Huntington Hospital
- Camden Clark Medical Center
- Charleston Area Medical Center
- Davis Medical Center
- Ohio Valley Medical Center
- St. Mary's Medical Center
- United Hospital Center
- Wheeling Hospital
- WVU Hospital

AHA and Million Hearts® Spotlight on West Virginia

Quality & Systems Improvement Priorities

2017 *Mission: Lifeline EMS Recognition*

- Berkeley County Emergency Ambulance Authority
- Cabell County EMS
- Harrison County EMS
- Kanawha County Emergency Ambulance Authority
- Marion County Rescue Squad
- Martinsburg Fire Department
- Mon EMS
- Morgan County EMS
- Putnam County EMS
- Wheeling Fire Department

AHA and Million Hearts® Spotlight on West Virginia

Quality & Systems Improvement Priorities

Target: BP - **Can Make A Difference**

- AHA and AMA partnered and launch Target: BP in 2015
  - to improve blood pressure control and build a healthier nation.
- National initiative to reduce the number of Americans who have heart attacks and strokes by urging medical practices, health service organizations, and patients to prioritize blood pressure control.
- Based on the most current AHA guidelines, Target: BP supports physicians and care teams by offering access to the latest research, tools, and resources to reach and sustain blood pressure goal rates of less than 140/90 mmHg within the patients populations they serve.
- https://targetbp.org/

Blood Pressure Strategies

Current Prevalence:

33 Million

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

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

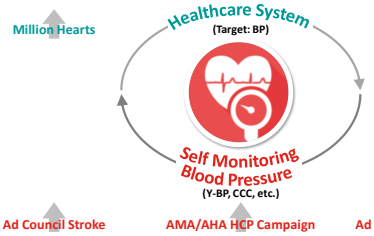
Increase % of hypertensive patients that are self-monitoring through community and employer based SMBP programs *(Y-BP and CCC)* — **IMPACT:** 500K (Complementary)

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

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. | Check. Change. *Control.* CHOLESTEROL

life is why

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

- 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.

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
- Get With The Guidelines – www.heart.org/quality
- Check.Change.Control
- Target: BP - https://targetbp.org/

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

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Million Hearts®

Q & A

Million Hearts®

CATERED LUNCH

Resume at 12:15

Million Hearts®

AFTERNOON BREAKOUTS / FACILITATED DISCUSSIONS

John Bartkus, PMP, CPF
Principal Program Manager, Pensivia

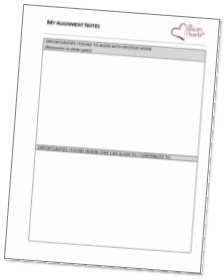
Workgroup Approach

Define the Destination

Plan the Route

Drive !

Use this Conversation as a Vehicle to Identify & Cultivate Alignment.



Afternoon Workgroup Meeting Rooms

1 Community Health Workers	2 Community Pharmacists / Physicians	3 Hypertension Control	4 Medication Adherence	5 Team Based Care
Kanawha Room	Mountain State Room	Capitol City C	Capitol City A	Capitol City B
Adam Baus **Scott Eubank** Whitney Garney Julie Harvill	**Krista Capehart** Christine Compton Julia Schneider	**Debbie Hennen** **Julie Williams** Tim Lewis Robin Rinker	**Stephanie Moore** **Cynthia Keeley** John Clymer Mary Jo Garofoli	**Jessica Wright,** **Carla Van Wyck** Miriam Patanian April Wallace

Workgroups have until 2:00pm. At 2:10pm, Report-Outs Start!

REPORTS FROM WORKGROUPS AND PLANS FOR FOLLOW-UP

Start at 2:10 !

EVALUATION AND FEEDBACK PROCESS

Whitney R. Garney

WRG Consulting

WRAP UP & ADJOURN

April Wallace

Program Initiatives Manager, Million Hearts® Collaboration