Advancing Million Hearts®:

AHA and State Heart Disease and Stroke Partners Working Together in Louisiana

September 25, 2019 – 8:30 AM to 3:00 PM Central
Louisiana State University – Lod Cook Alumni Center
3838 West Lakeshore Drive
Baton Rouge, Louisiana

8:30 am – Networking

9:00 am – Meeting Starts

Million Hearts®

Welcome and Opening Remarks

JOHN CLYMER
Executive Director
National Forum for Heart Disease and Stroke Prevention
Co-chair, Million Hearts® Collaboration

Welcome and Opening Remarks

JULIE HARVILL

Operations Manager
Million Hearts® Collaboration

American Heart Association

JOHN CLYMER

Executive Director
National Forum for Heart Disease and Stroke Prevention
Co-chair, Million Hearts® Collaboration

Overview of the Day

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

Million Hearts® in Action (2013-2019)

Purpose and Outcomes

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 and identify strategies for Million Hearts® priorities.

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

- Welcome & Overview of the Day
- Introductions
- Million Hearts® 2022 Update
- Louisiana Department of Health Hypertension Initiatives
- Quality Insights, Quality Innovation Network
- American Heart Association Hypertension Initiatives

- Louisiana Partner Hypertension Initiatives
  - Partnering with providers to implement sustainable systems changes
  - Bogalusa Heart Study and Hypertension
  - Louisiana Perinatal Quality Collaborative
  - Sankofa Community Development Corporation
  - Rural Health Center Hypertension Programs

- Lunch @ 12:00 noon

- Facilitated Discussions / Breakouts (x3)

- Group Report Outs and Next Steps
- Evaluation and Feedback Process
- Wrap up / Adjourn

Introductions

JOHN BARTKUS

Principal Program Manager
Pensivia

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Alignment

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

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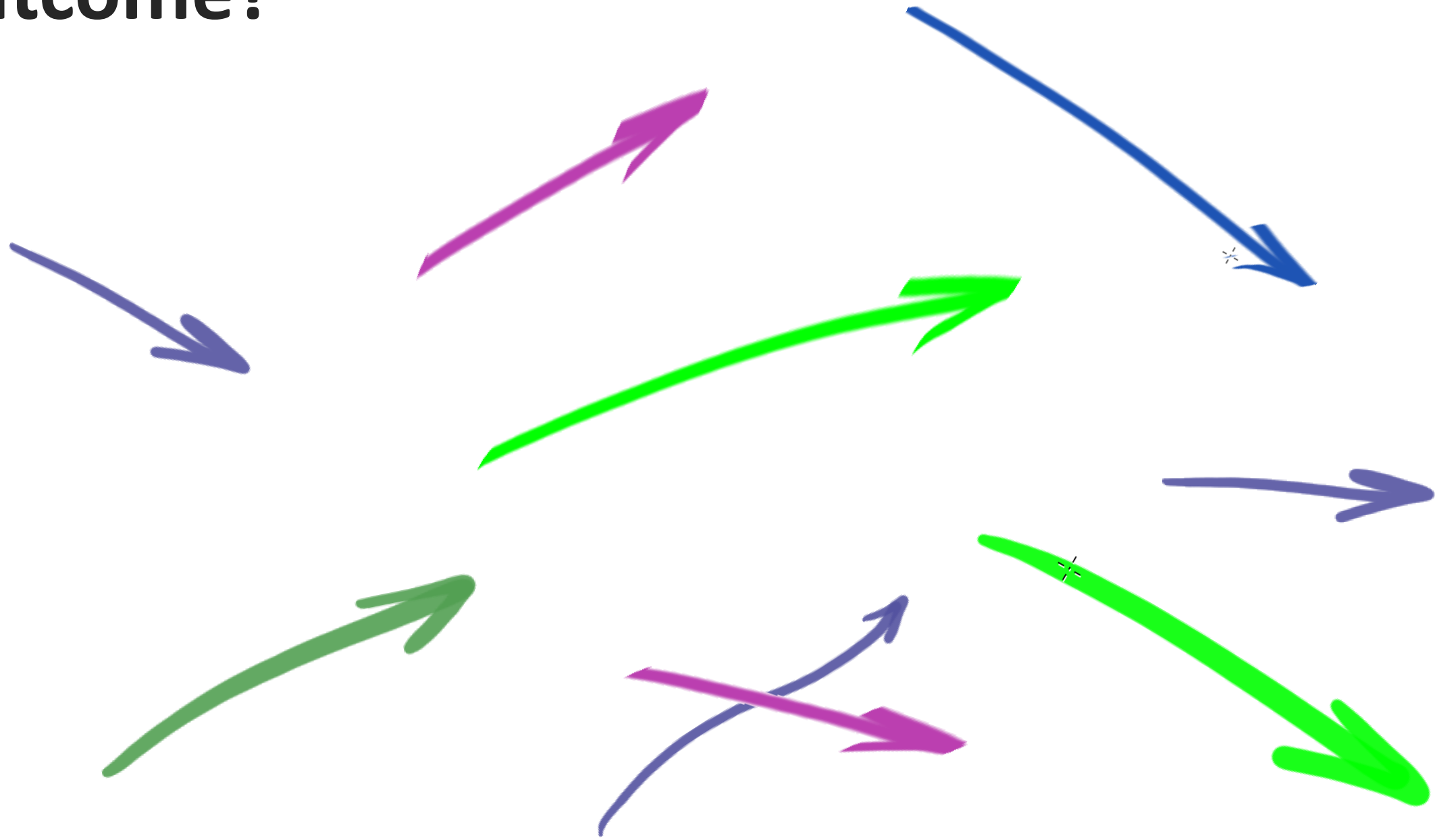
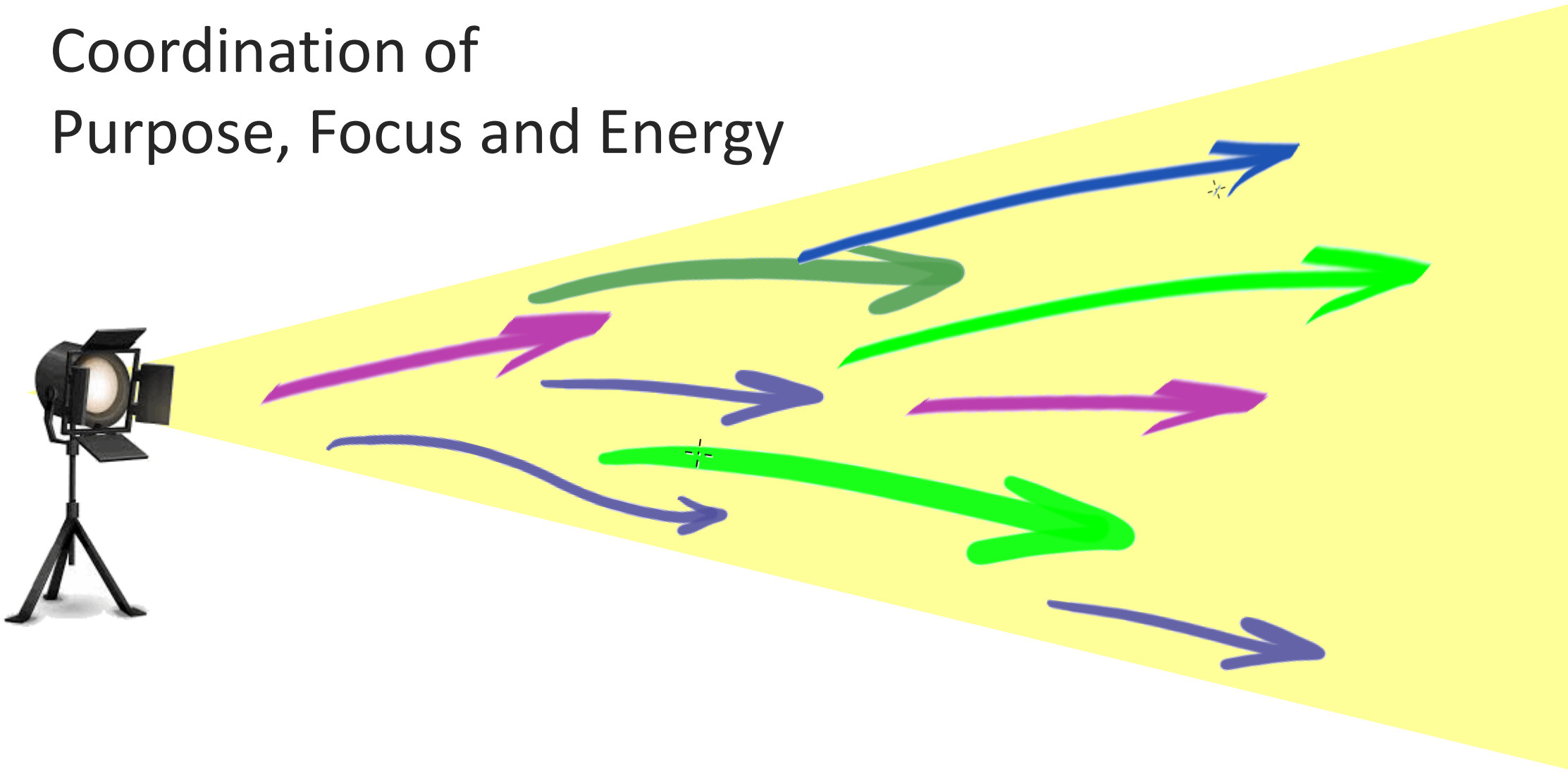
Outcome?



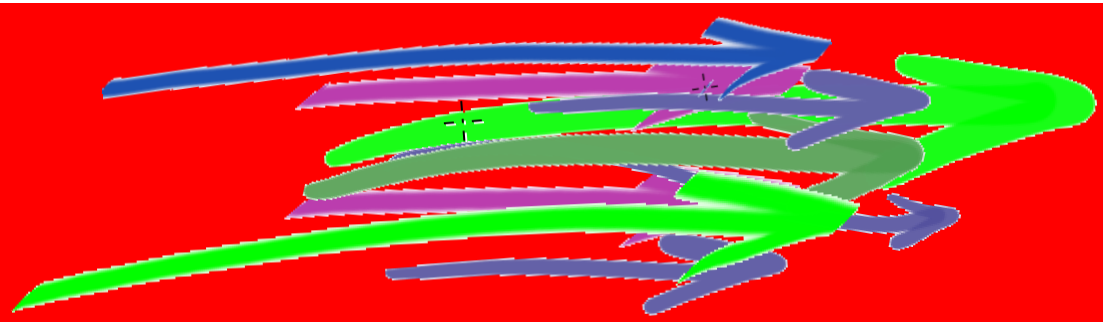
Alignment

Coordination of
Purpose, Focus and Energy



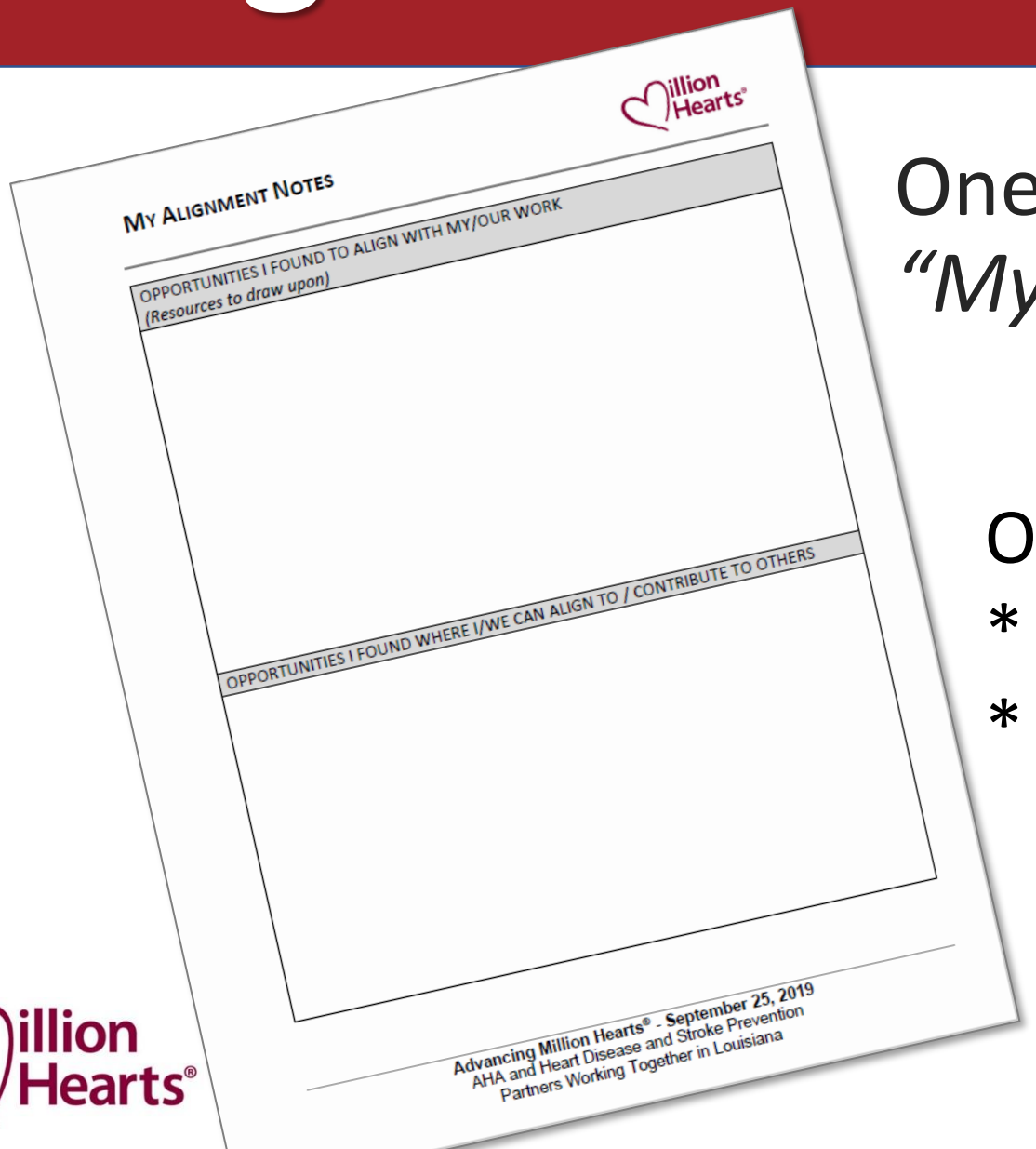
Alignment

Coordination of
Purpose, Focus and Energy



Higher Impact on the target

Alignment and Connections



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

Opportunities I found to:

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

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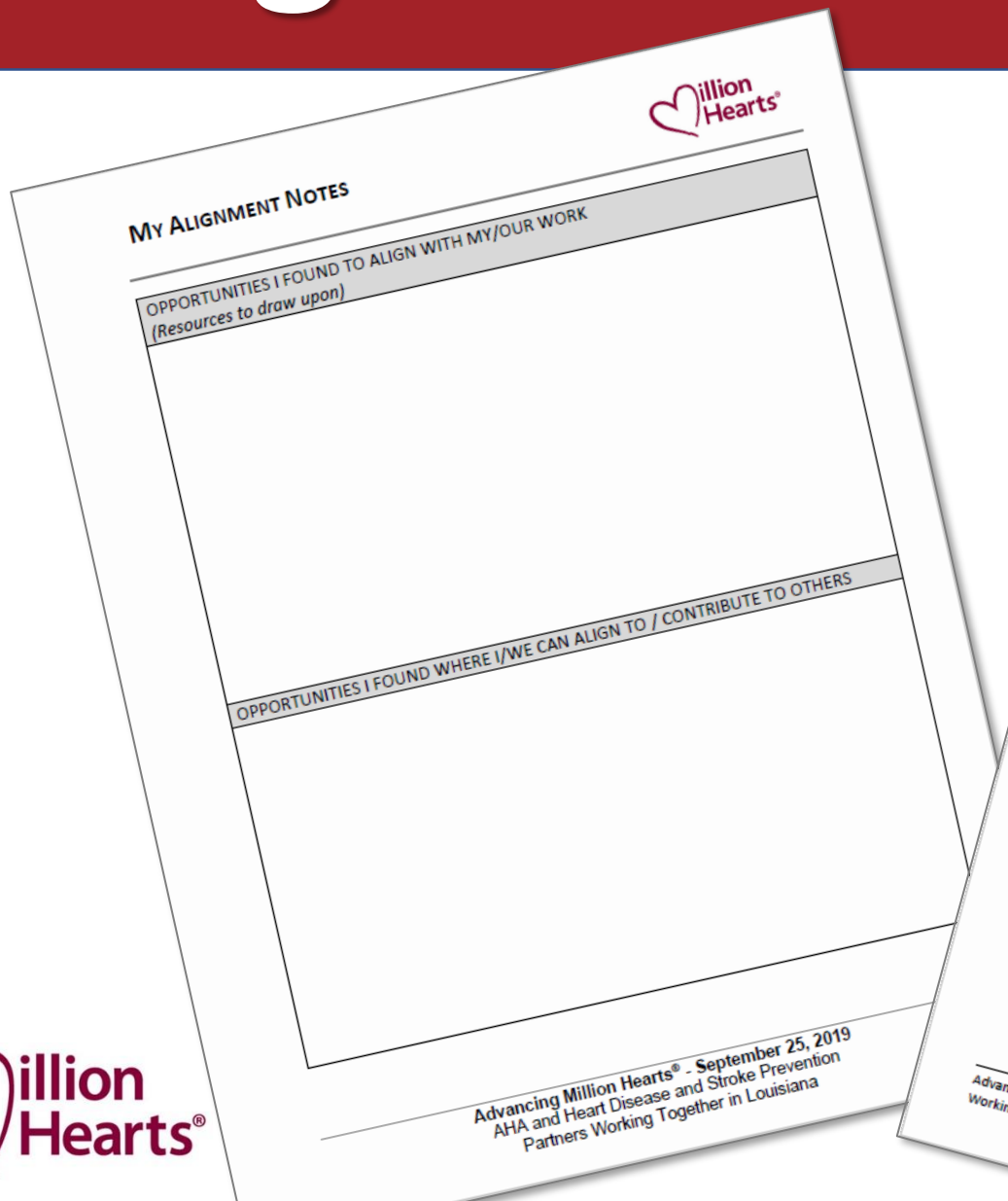
Alignment and Connections



Leverage your

Partner Profiles

which came from the pre-meeting questionnaire.

15 Second Introductions

Name & Organization

“One thing I want from today is …”

(One Sentence)

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Million Hearts® 2022 Overview and Update

TIFFANY FELL

Deputy to Associate Director

Policy, External Relations, and Communications Office

Division for Heart Disease and Stroke Prevention

National Center for Chronic Disease Prevention and Health Promotion

Centers for Disease Control and Prevention

Preventing 1 Million Heart Attacks and Strokes by 2022

Tiffany Fell
Deputy Associate Director, PERC
Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention

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Million Hearts® 2022

- **Aim:** Prevent 1 million—or more—heart attacks and strokes by 2022
- 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 in the U.S. 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]

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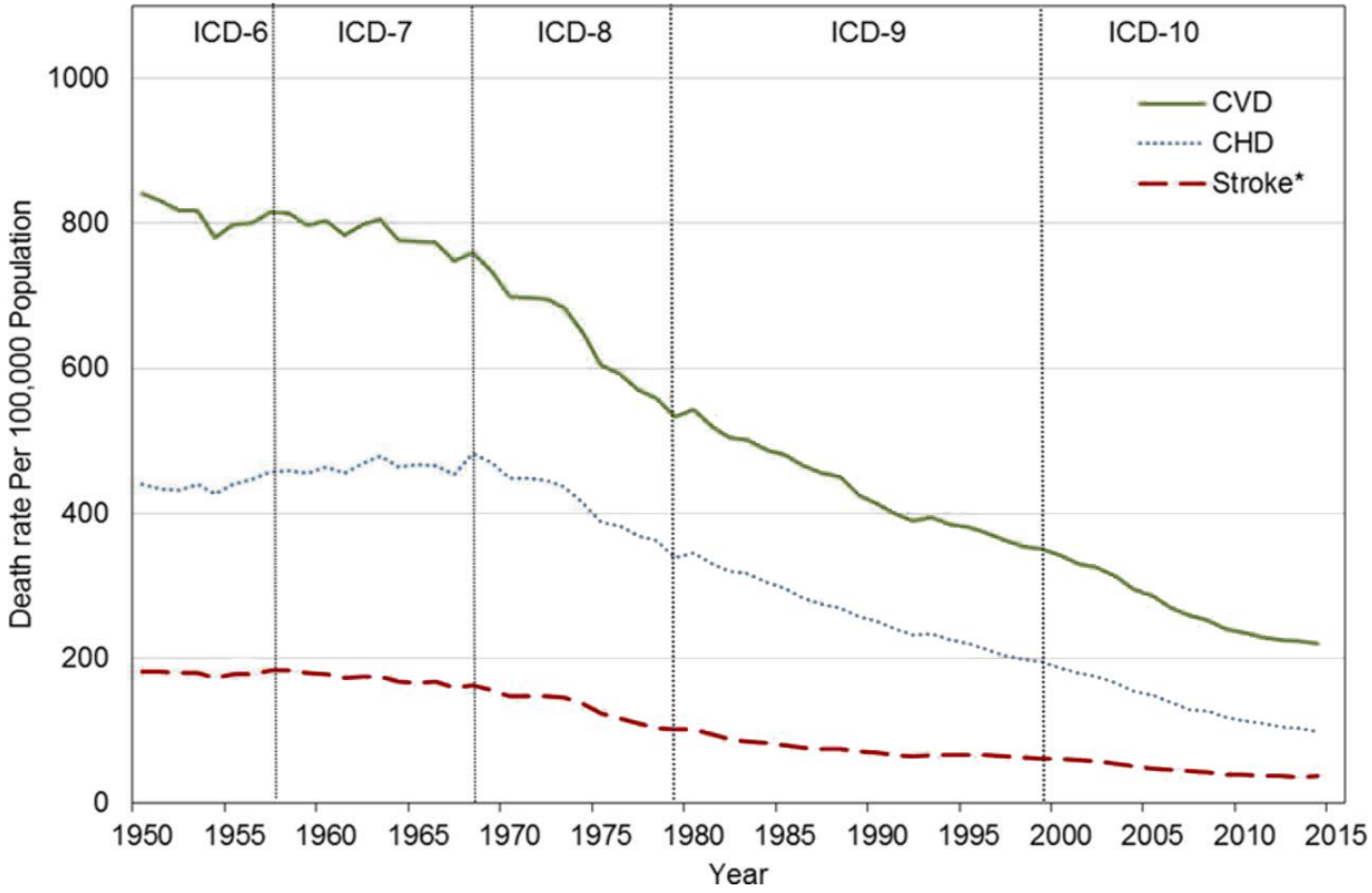
References

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

Heart Disease and Stroke Trends 1950–2015



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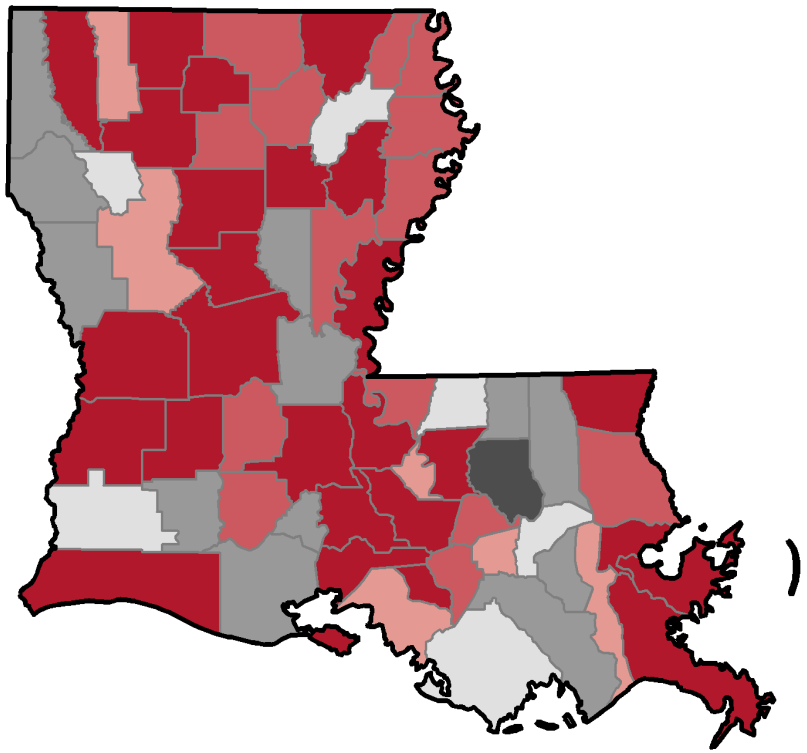
Mensah GA, Wei GS, Sorlie PD, Fine LJ, Rosenberg Y, Kaufmann PG, et al. Decline in cardiovascular mortality: possible causes and implications. Circ Res 2017;120:366–80.

Parish-level death rates

County-level total percent change in heart disease death rates, Louisiana, ages 35-64, 2010-2017



Percent change

- Decrease of 10.0 or greater (1.6%)
- Decrease of 2.0 to 10.1 (18.8%)
- Decrease of 0.0 to 2.1 (9.4%)
- Increase of 0.1 to 2.0 (9.4%)
- Increase of 2.1 to 10.0 (21.9%)
- Increase of 10.1 or greater (39.1%)

Heart disease death rates are increasing in over two-thirds of parishes.

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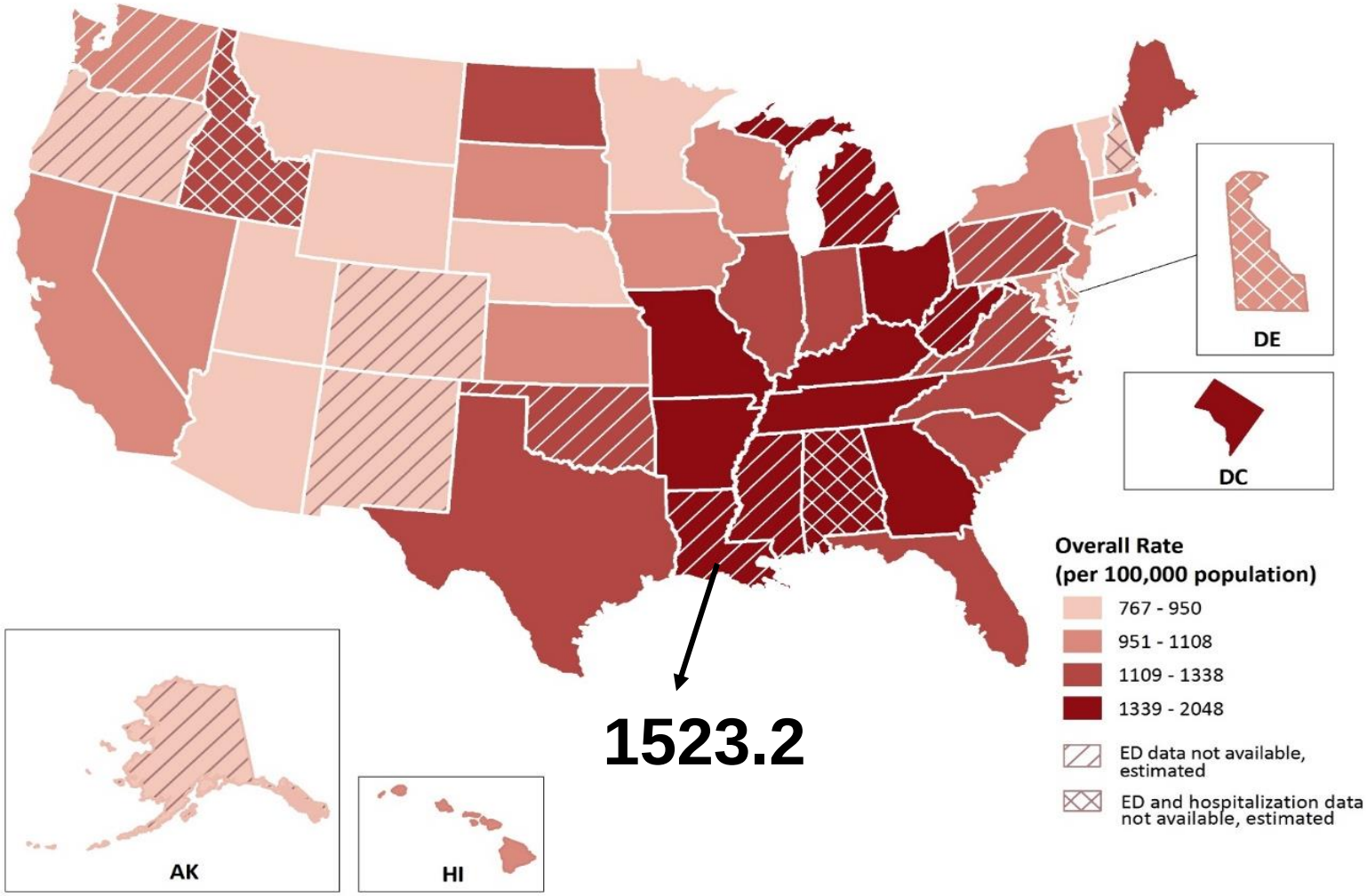
Million Hearts-preventable event rates among adults aged ≥18 years by state, 2016



Data Sources: Healthcare Cost and Utilization Project data (2016), National Vital Statistics mortality data (2016);
Ritchey MD, Wall HK, Owens PL, Wright JS. Vital Signs: State-level Variation in Non-fatal and Fatal Heart Disease and Stroke Events Targeted for Prevention by Million Hearts 2022. MMWR. 2018;67(35):974-982.

What this means for Louisiana

- We project **279,300** “Million Hearts preventable events” that will occur in LA if we do nothing

- 6% reduction of those events = **16,800 events** we hope LA will prevent

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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 with hypertension
35- to 64-year-olds
People who have had a heart attack or stroke
People with mental and/or substance use disorders

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

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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

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Optimizing Care

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

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

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Improving Outcomes for Priority Populations

Population	Intervention Needs	Strategies
Blacks/African Americans with hypertension	• Improving hypertension control	• Targeted protocols • Medication adherence strategies
35- to 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 and/or substance use disorders	• Reducing tobacco use	• Integrating tobacco cessation into behavioral health treatment • Tobacco-free mental health and substance use treatment campuses • Tailored quitline protocols

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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
- **Messages and Resources**—Undiagnosed Hypertension, Medication Adherence, Health IT, SMBP, Particle Pollution, Physical Activity, Tobacco Use
- **Clinical Quality Measures**
- **Consumer Resources and Tools**

Million Hearts® 2022 Website: https://millionhearts.hhs.gov/

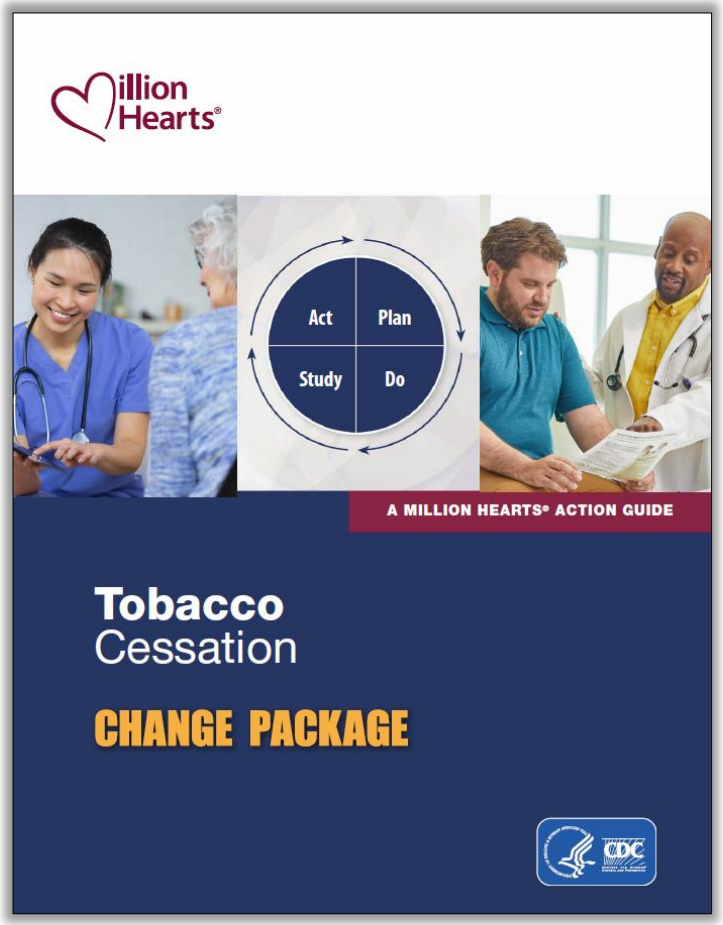
Tobacco Cessation Change Package (TCCP)

Table 1. Key Foundations

Change Concept	Change Idea	Tools and Resources	Settings
Make Tobacco Cessation a Practice and System Priority	Identify one or two key champions and assemble a multidisciplinary team	Center of Excellence for Health Systems Improvement for a Tobacco-Free NY — Supporting Evidence-Based Tobacco Dependence Screening & Treatment (p. 155)	○ △ □
		ICSI — Tobacco Health Systems Change Starter Toolkit for Clinics (pp. 5–6)	○ △ □
		UW Health, UW-Madison SMPH, and UW-CTRI — Quit Connect Health: A Specialty Staff Protocol to Improve Referrals to Tobacco Quit Lines (pp. 12–13)	○ △ □
		UW-CTRI — Treating Tobacco Use and Dependence in Hospitalized Patients: A Practical Guide (p. 9)	△
	As a multidisciplinary group, conduct a assessment of yo clinic/system and develop an actio plan to address t current gaps (*continued on next page*)		

Table 3. Screening

Change Concept	Change Idea	Tools and Resources	Settings
Make Tobacco Use a Vital Sign: Screen Every Patient for Tobacco Use at Every Visit	Adopt a tobacco use screening protocol	Million Hearts® — Protocol for Identifying and Treating Patients Who Use Tobacco	○ △ □
		NYC DOHMH and HealthyHearts NYC — ABCS Toolkit for the Practice Facilitator (p. 84)	○
		UW Health, UW-Madison SMPH, and UW-CTRI — Quit Connect Health: A Specialty Staff Protocol to Improve Referrals to Tobacco Quit Lines (p. 10)	○
		UW-CTRI — Treating Tobacco Use and Dependence in Hospitalized Patients: A Practical Guide (pp. 8, 13–14)	△
		UCSF SCLC — Destination Tobacco Free: A Practical Tool for Hospitals and Health Systems (pp. 6–7, Appendix N)	△
	Establish a workflow and determine roles for tobacco use screening and documentation	Center of Excellence for Health Systems Improvement for a Tobacco-Free NY — Supporting Evidence-Based Tobacco Dependence Screening & Treatment (pp. 148–153)	○ △ □
		ICSI — Tobacco Health Systems Change Starter Toolkit for Clinics (pp. 24–26)	○ □
		CU Anschutz Medical Campus — A Patient-Centered Tobacco Cessation Workflow for Healthcare Clinics (pp. 2–4)	○ □
	Embed a tobacco use status prompt in the EHR or other patient record-keeping system (*continued on next page*)	CA Quits — CA Quits Toolkit (pp. 7–8)	○ △ □
		NYC Health & Hospitals — EHR Screenshots (Epic): Ambulatory Tobacco Screening and Treatment Workflow (pp. 1–5)	○ △ □
		UW Health, UW-Madison SMPH, and UW-CTRI · Quit Connect Health: A Specialty Staff Protocol to Improve Referrals to Tobacco Quit Lines (pp. 14–28) · Quit Connect Health Overview and Staff Instructions (p. 11)	○ △ □



Access the Change Package at:
https://millionhearts.hhs.gov/files/Tobacco_Cessation_Change_Pkg.pdf

Million Hearts® in Municipalities Toolkit

- MODULE 1: OVERVIEW
- MODULE 2: SETTING GOALS
- MODULE 3: PARTNERSHIPS
- MODULE 4: COMMUNICATION
- MODULE 5: EVALUATION & MONITORING

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NACCHO
National Association of County & City Health Officials

Hypertension Control Change Package

Table 1. Hypertension Control Change Package—Key Foundations (continued)

Change Concepts	Change Ideas	Tools and Resources
Implement a Policy and Process to Address BP for Every Patient with HTN at Every Visit	Develop HTN control policy and procedures	• American Medical Group Foundation. Provider Toolkit to … Hypertension Control. BP Addressed for Every Hype… Every Primary Care or Cardiology Visit: http://bit.ly/1nqETWJ* • Kaiser Permanente. Blood Pressure Ch… http://bit.ly/1nqETWJ*
	Leverage local Patient Centered Medical Home (PCMH) activities to help drive comprehensive approach to HTN management	• Washington State D… Prevention, an… for Clinic P… (pp. …
	Develop a flo… how hyp… will…	
	…e guidan… measuring BP	
	…aluate …are Staff …Accurate BP Measurement and Recording	
	Assess adhere… BP measureme…	

…—Population Health Management

		Tools and Resources
		• American Medical Group Association. Registry Used to Track Hypertension Patients: http://bit.ly/12k9MT1*
	…nts with …BP yet without a …N diagnosis; diagnose HTN as appropriate	• Health Center Network of New York. Undiagnosed Hypertension Registry: http://bit.ly/1sUmOPG
	Use a defined process for outreach (e.g., via phone, mail, email, text message) to patients with uncontrolled HTN and those otherwise needing follow-up	• Redwood Community Health Coalition. Hypertension Recall Instructions: see Appendix B. • The Office of the National Coordinator for Health Information Technology. Quality Improvement in a Primary Care Practice: http://bit.ly/1tgdXdO • American Heart Association. Heart360. An Online Tool for Patients to Track and Manage Their Heart Health and Share Information: http://bit.ly/1hVJCWv
Use Clinician-Managed Protocols for Medication Adjustments and Lifestyle Recommendations	Use protocols to cover proactive outreach driven by registry use and respond to patient-submitted home BP readings	• Minnesota Board of Nursing. FAQ: Use of Condition-Specific Protocols: http://bit.ly/1wFw8YD • Kaiser Permanente. Protocol for Uncomplicated Hypertension: Registered Nurse Titration of Lisinopril, Hydrochlorothiazide, Atenolol, and Amlodipine: http://bit.ly/1u8SSsR • UNC Health Care Center. Standing Order: Antihypertensive Initiation and Titration: http://bit.ly/1thJlrE • Agency for Healthcare Research and Quality. Blood Pressure Titration Protocol for Diabetes Planned Visit: http://1.usa.gov/1rABLmk • Mercy Clinics, Inc. Hypertension Standing Orders: http://bit.ly/1032em6*
Use Practice Data to Drive Improvement	Determine HTN control metrics for the practice	• Washington State Department of Health. Improving the Screening, Prevention, and Management of Hypertension—An Implementation Tool for Clinic Practice Teams: Measurement Worksheet (pp.12-15): http://bit.ly/ZGoe6e • Health Center Network of New York. Specifications Hypertension Measures: http://bit.ly/1xErvxU
	Regularly provide a dashboard with BP goals,	• New York City Department of Health. Provider Dashboards: http://bit.ly/1wFB9Ao • New York City Department of Health. John Doe Dashboard: http://bit.ly/1zKuSsx ◦ More detailed information: Your Practice Hypertension Panel Summary (http://bit.ly/1z31ADT) and Hypertension Panel Management Patient List

Revised version coming in 2019

http://millionhearts.hhs.gov/Docs/HTN_Change_Package.pdf

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Hospitals & Health Systems

Recognize hospitals working systematically to improve the cv health of population/communities they serve by:

1. Keeping People Healthy
2. Optimizing Care
3. Improving Outcomes for Priority Populations
4. Innovating for Health

- Applicants must address a *minimum of one* strategy in at least *three of the four* priority areas

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Application Process

Applicants can be recognized for— *committing*, *implementing*, or *achieving* — for each strategy they intend to address

- *Committing* – no data required other than your commitment to implement
- *Implementing* – must submit the data per strategy listed as “Required attestation for those implementing”
- *Achieving* – must submit the data per strategy listed as “Recommended outcomes for those achieving results”

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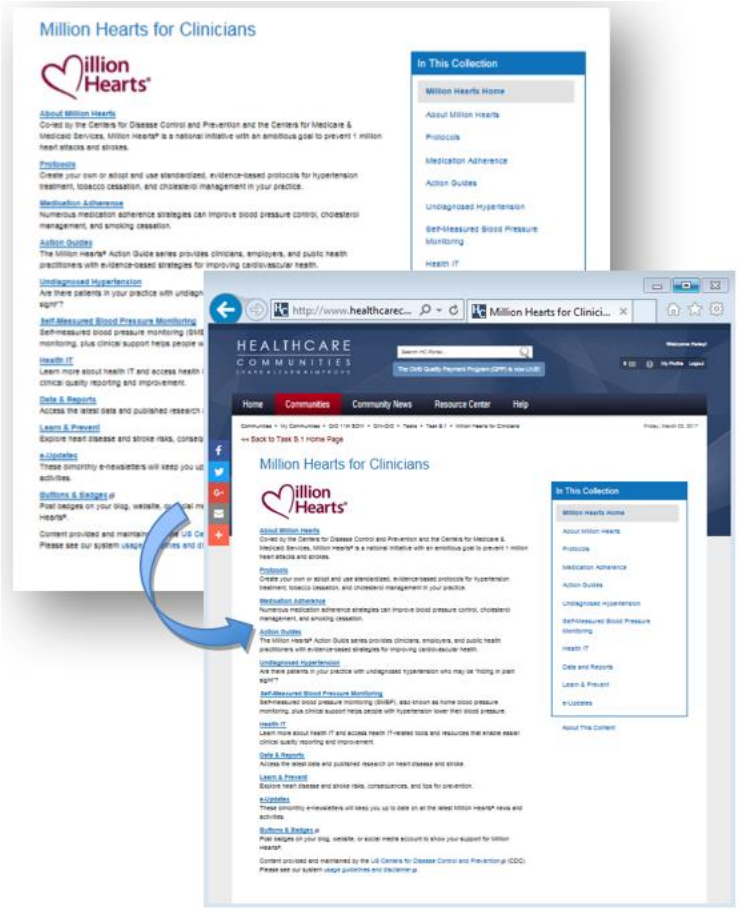
Million Hearts® for Clinicians Microsite

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



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

Stay Connected

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

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Louisiana Department of Health Hypertension Initiatives

MELISSA R MARTIN, RDN, LDN
Well-Ahead Louisiana Director

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Connecting Louisiana Communities to a Healthier Future,

a focus on Heart Disease Prevention and Management

Louisiana's Health Initiative

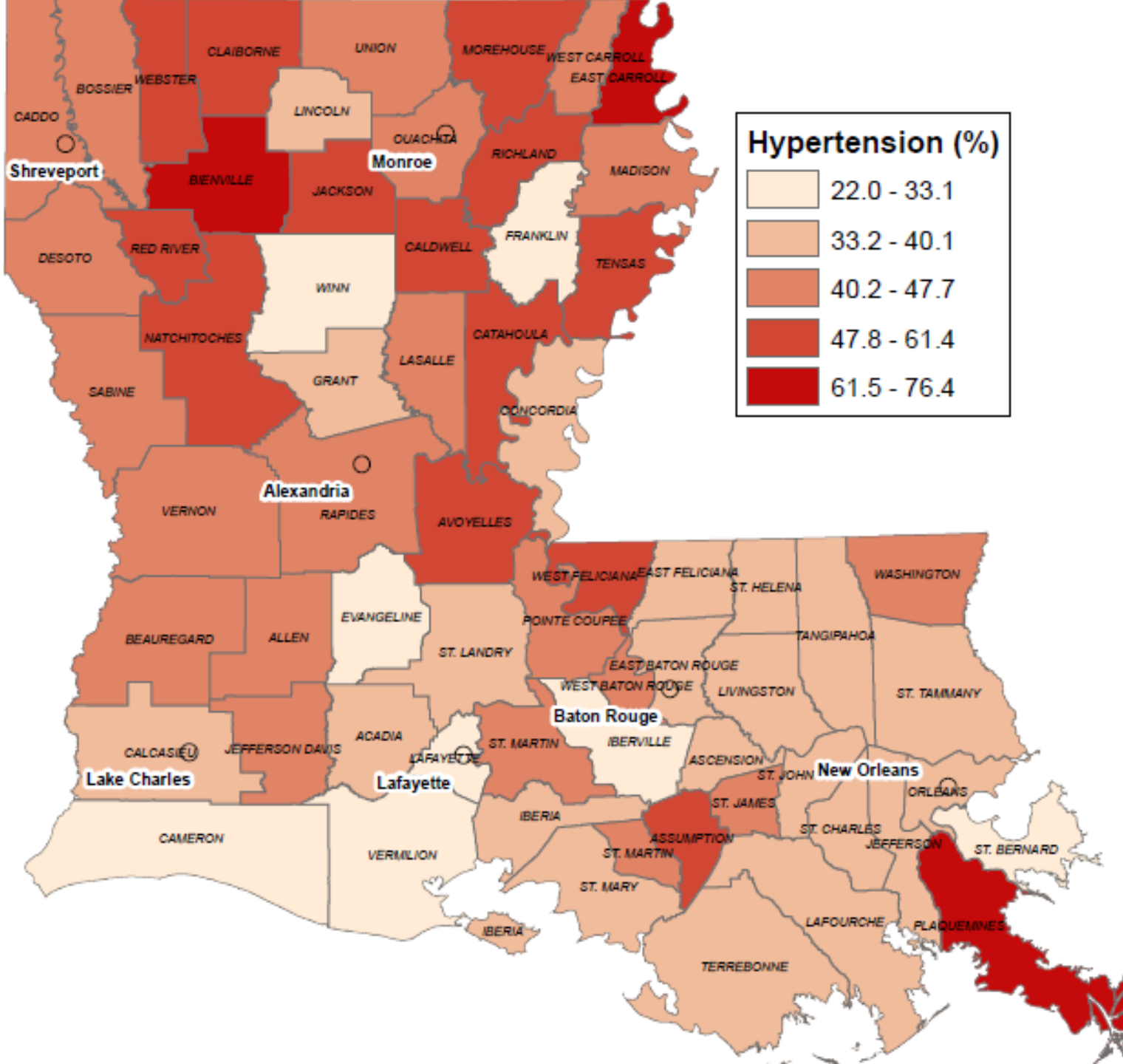
Connecting Louisiana Residents to a Heathier Future

- State Office of Rural Health
- Medicare Rural Hospital Flex
- Small Hospital Improvement Program
- State Loan Repayment
- Rural Provider Support Programs
- Primary Care Office
- HPSA Designation
- State Refugee Program
- Early Care and School Health Promotion
- Obesity and Management Prevention
- Diabetes Management and Prevention
- Heart Disease Management and Prevention
- Oral Health Promotion
- Tobacco Cessation and Prevention
- WellSpot Designation
- Healthy Community Design

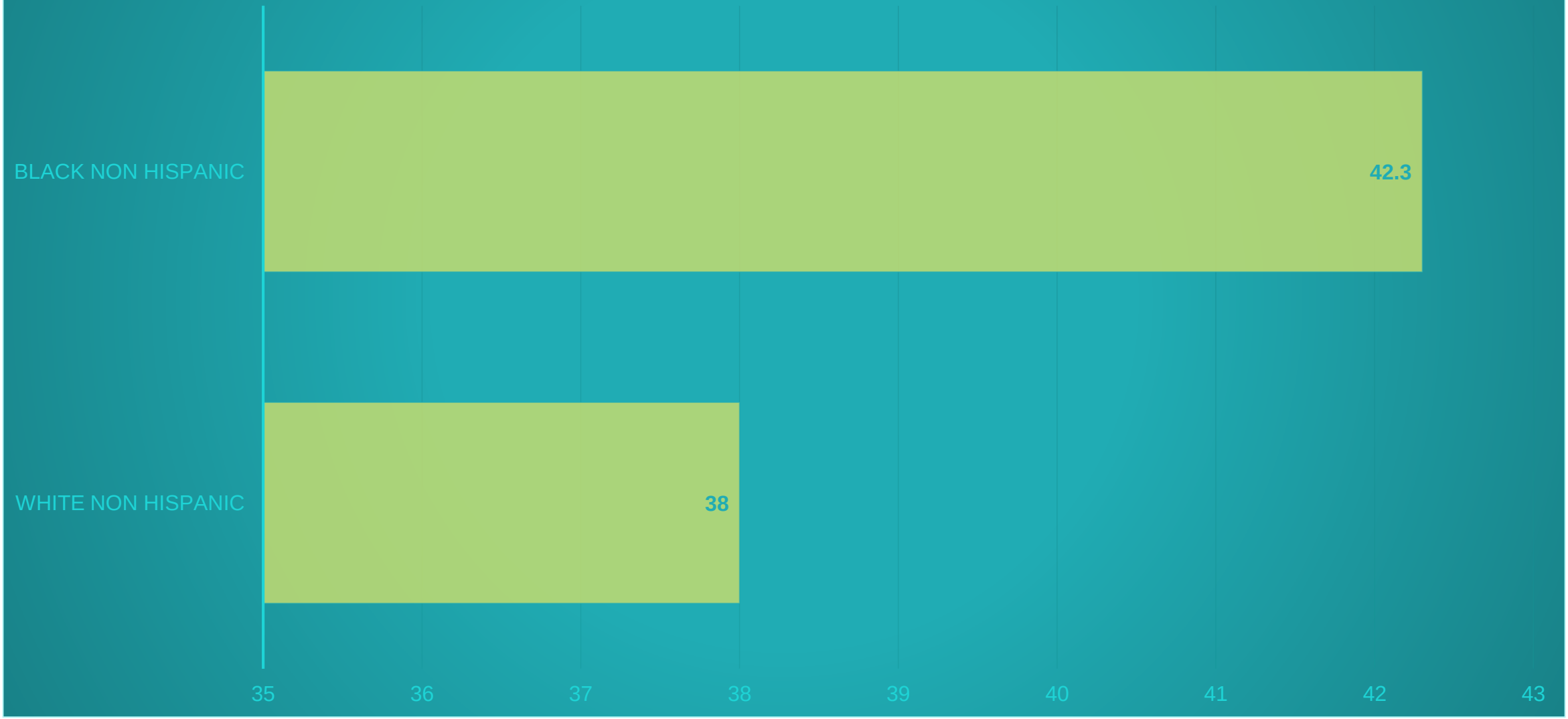
Louisiana Data

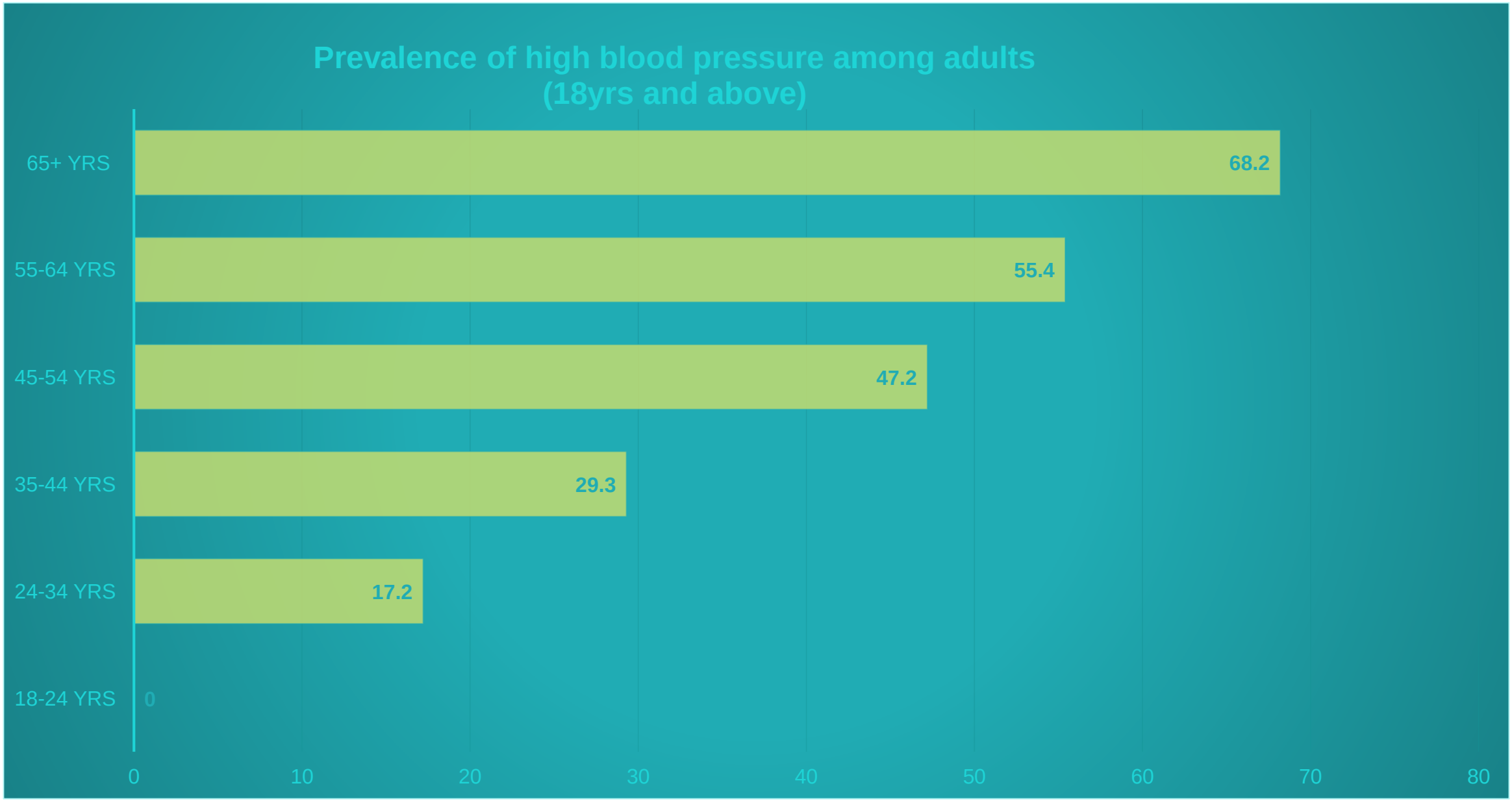
Prevalence of High Blood Pressure by Parish amongst Louisiana Adults 18 years and older

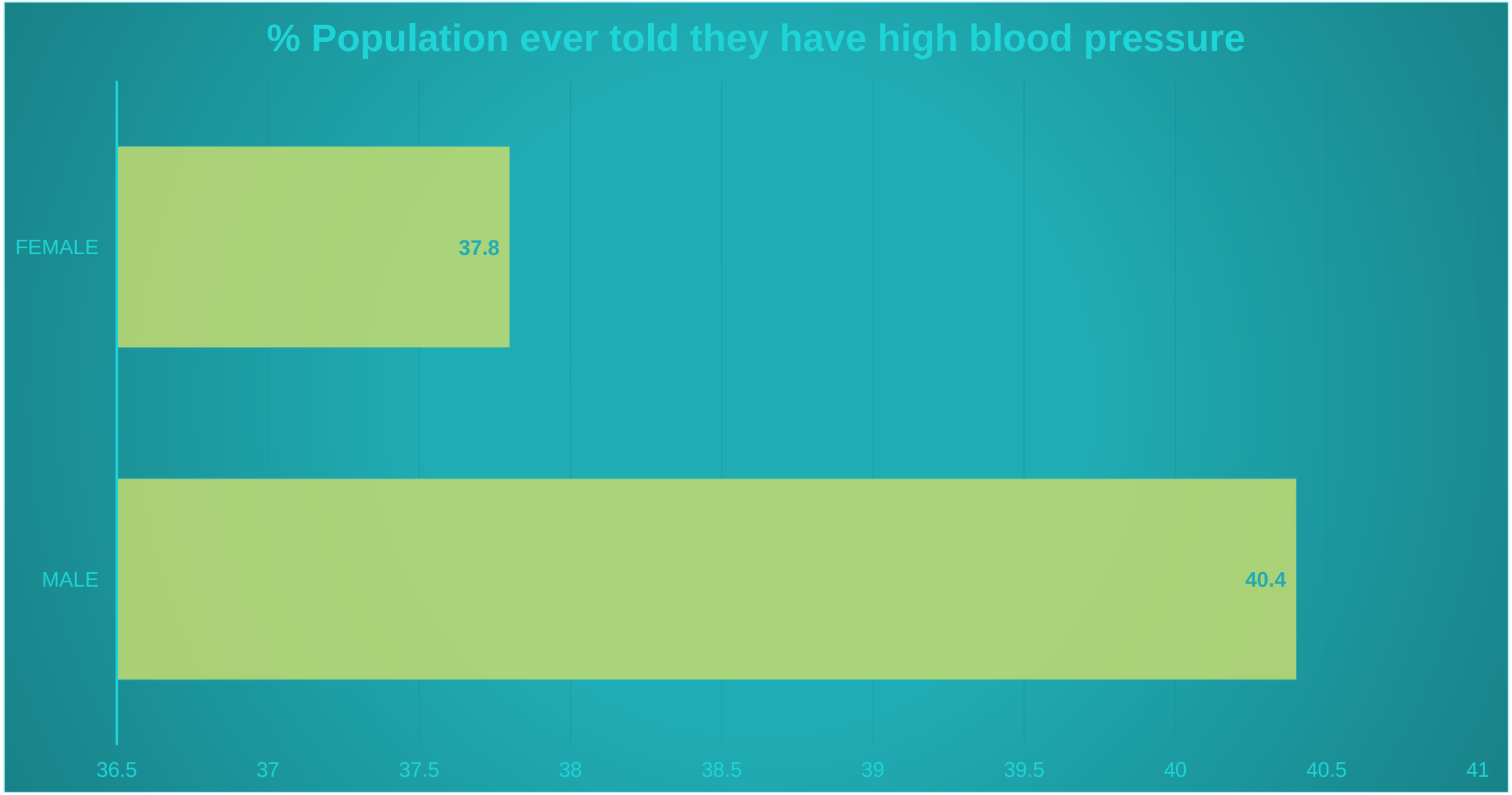
Source:
BRFSS 2015, 2017



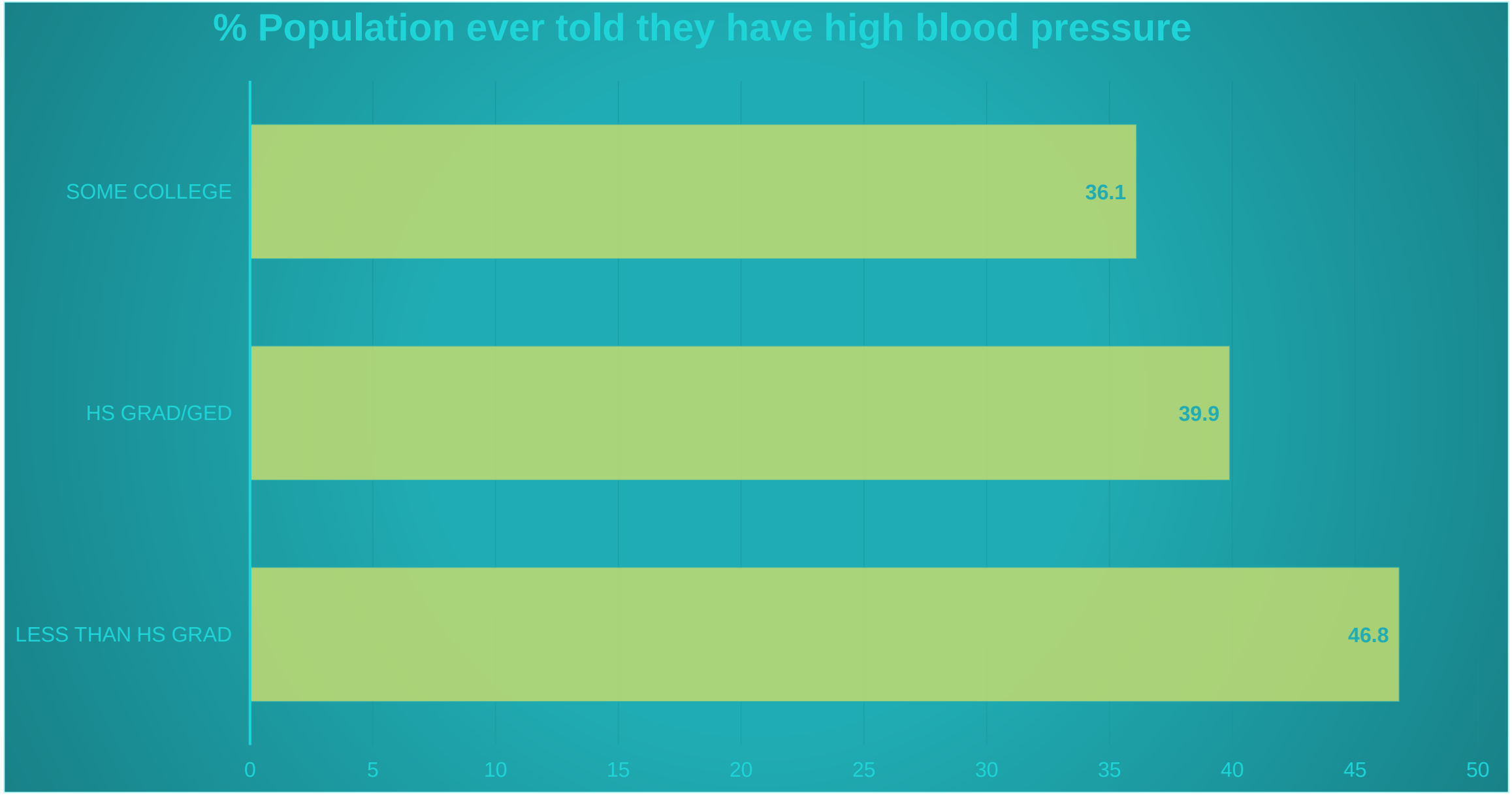
Prevalence of high blood pressure among adults (18yrs and above)

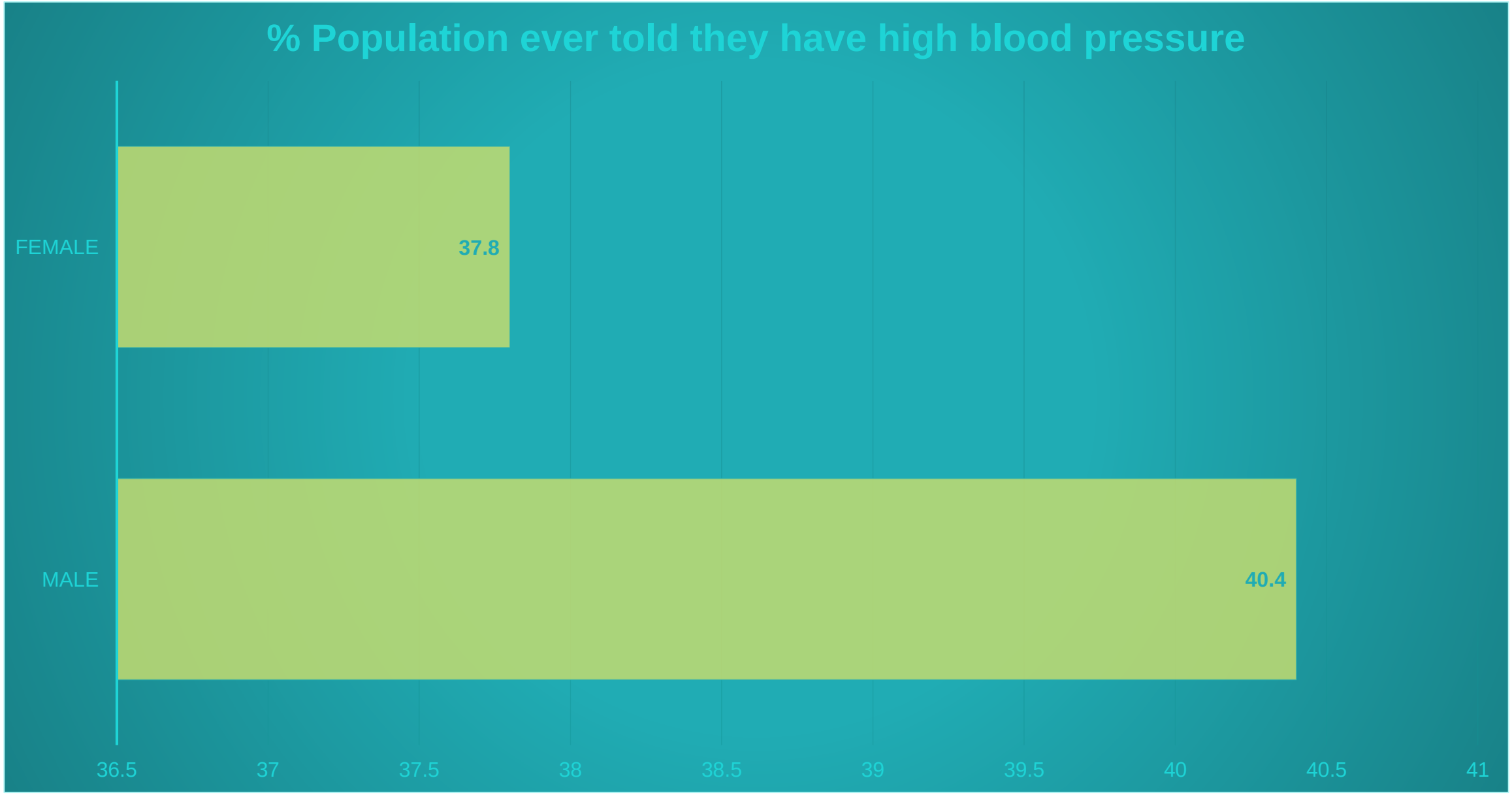



Prevalence of high blood pressure among adults
(18yrs and above)
65+ YRS
68.2
55-64 YRS
55.4
45-54 YRS
47.2
35-44 YRS
29.3
24-34 YRS
17.2
18-24 YRS
0
0
10
20
30
40
50
60
70
80


% Population ever told they have high blood pressure
FEMALE
37.8
MALE
40.4
36.5
37
37.5
38
38.5
39
39.5
40
40.5
41


% Population ever told they have high blood pressure
>=50,000
34.3
35,000-49,999
40.3
25,000-34,999
41.4
15,000-24,999
43.7
LESS THAN 15,000
42.8
0
5
10
15
20
25
30
35
40
45
50


% Population ever told they have high blood pressure
SOME COLLEGE
36.1
HS GRAD/GED
39.9
LESS THAN HS GRAD
46.8
0
5
10
15
20
25
30
35
40
45
50


% Population ever told they have high blood pressure
FEMALE
37.8
MALE
40.4
36.5
37
37.5
38
38.5
39
39.5
40
40.5
41

Well-Ahead Heart Disease Prevention and Management

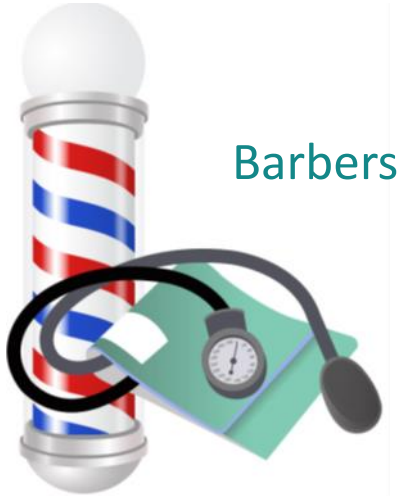
Public Health Approach: Policy, System, Environmental Change

- Policy
  - Interventions that create or amend laws, ordinances, resolutions, mandates, regulations, or rules.
- System
  - Interventions that impact all elements of an organization, institution, or system
- Environmental
  - Interventions that involve physical or material changes to the economic, social, or physical environment.

Community Resource Development and Healthy Community Coaching

Self-Monitoring Blood Pressure Programs with Clinical Support

WellSpot Designation



Barbershop Project

WELL-AHEAD
WELLAHEADLA.COM

WISE Woman

QUIT WITH US, LA
1.800.QUIT.NOW
QuitWithUsLa.Org

WELL-AHEAD
WELLAHEADLA.COM

PROVIDER EDUCATION NETWORK

Population Health Cohort

American Heart Association Partnership

Practice Coaches

Medication Adherence and Therapy Management

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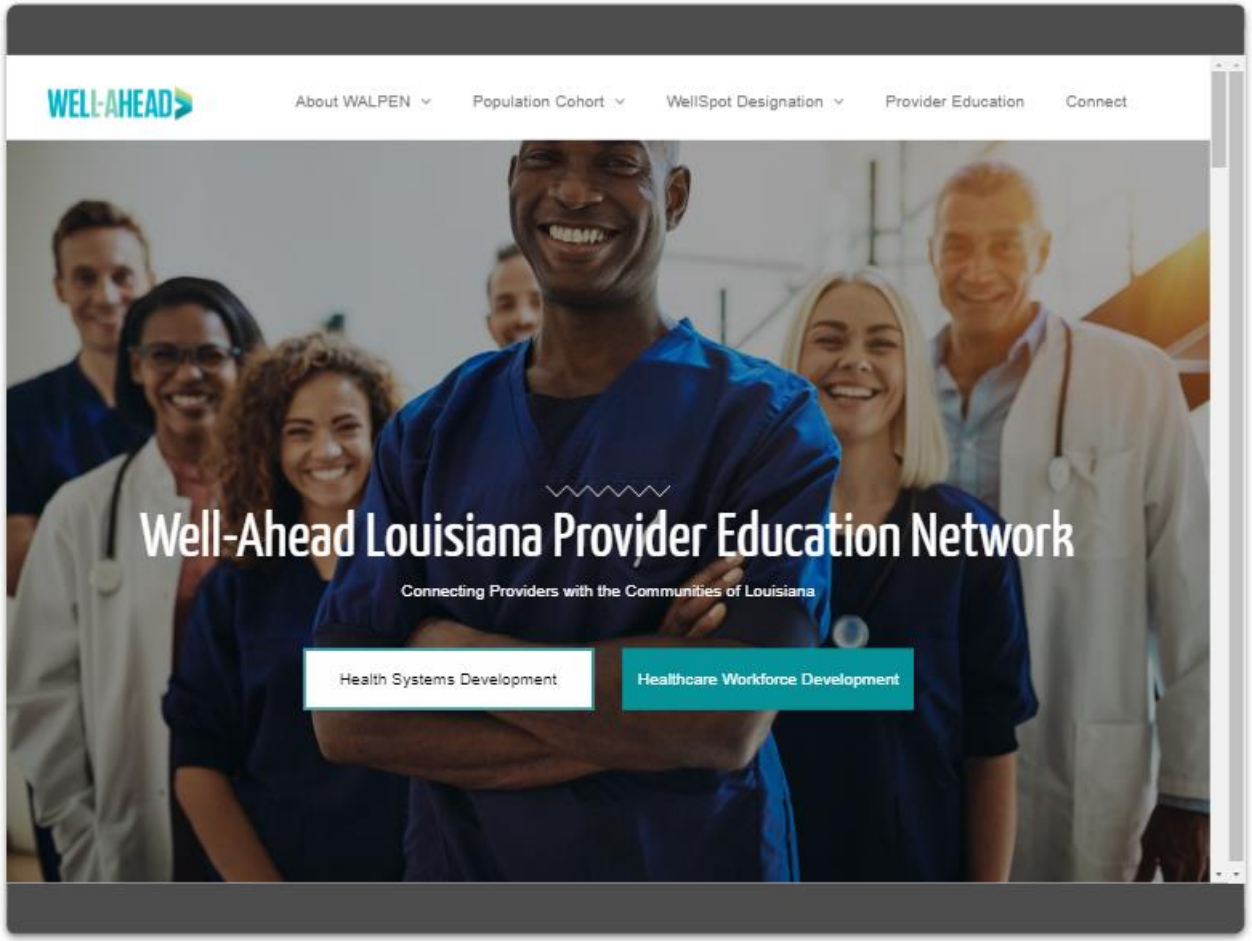
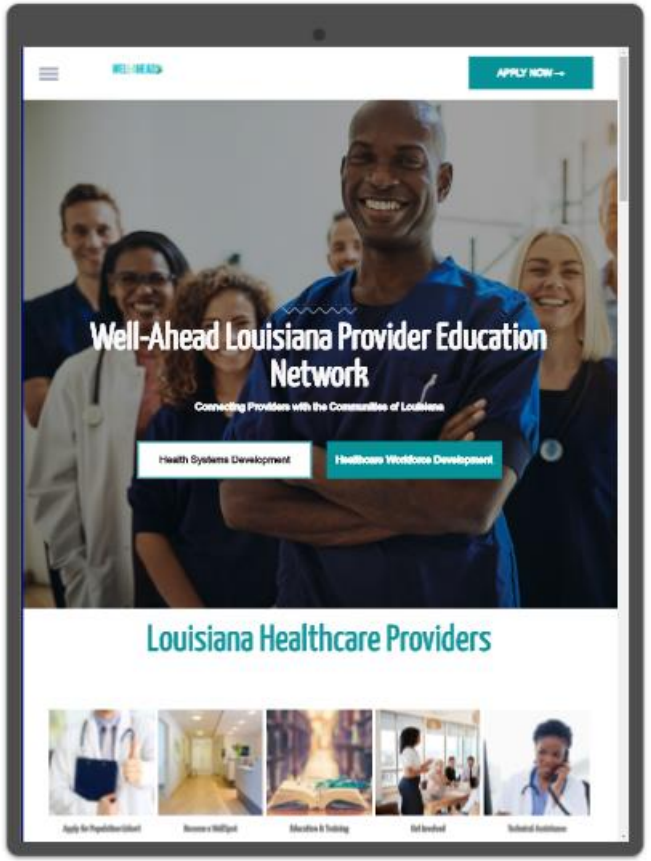
Bookmark www.walpen.org





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Provider Education Network

You Are Invited!

Pharmacist-Provided Medication Therapy Management: A Patient's Ally Against Chronic Disease

April 26th: 12:00pm - 1:00pm

The webinar will provide an overview of the application of Medication Therapy Management in managing a patient with chronic disease, such as hypertension or diabetes.

In this webinar, you will:

- Learn about Medication Therapy Management (MTM) and its components.
- Learn about opportunities to sustain your MTM services.
- Learn about strategies to promote your MTM services.

Click Here to Register for the Webinar.

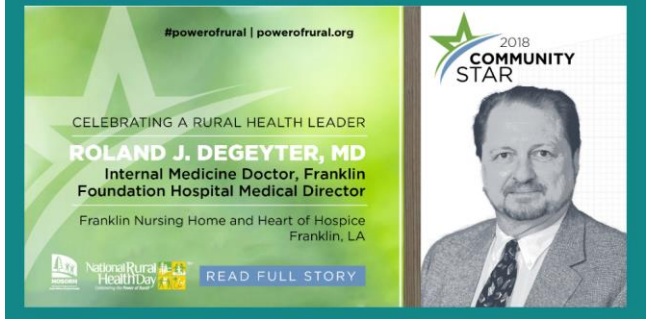
WELL-AHEAD

WELLAHEADLA.COM

Happy National Rural Health Day!

Well-Ahead Louisiana is proud to recognize three recipients of the National Organization of State Offices of Rural Health's prestigious Community Star Award. Thanks for helping us move Louisiana's health forward!

The Bogalusa Mayor's Wellness Council was awarded for bringing together a diverse group of partners to implement Bogalusa Strong. In less than a year, Bogalusa Strong was able to launch a citywide tobacco cessation campaign, host a healthy lunchroom workshop for Bogalusa school cafeteria staff, establish a bi-annual Mayor's walk, and more.



Provider Education Network

Our Brief Tobacco Intervention Provider Training is now available online!

21.9% of Louisiana adults smoke. The majority of those who smoke are interested in quitting, but rarely receive quit assistance.

Tobacco quit rates increase when healthcare providers consistently identify and treat tobacco use. Cessation advice should be offered to every patient!

As a healthcare provider, you have a great opportunity to make tobacco use screening and cessation service referral a standard of care among your healthcare team.

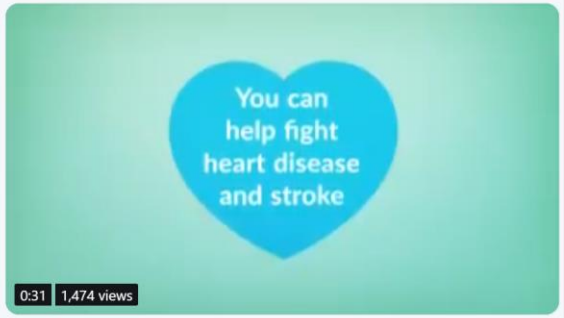
Over 100 providers have participated in our Brief Tobacco Intervention Training! Don't miss out! In the training you will:

Follow Us On Social Media

Well-Ahead Louisiana
Published by Sprout Social [?] · April 17 ·

Want to make a difference this Spring Break? Then join us April 23rd for a free Building Your Diabetes Education Program!
Wednesday, April 17th, is the last day to register. But don't worry you can do it right now by clicking this link:
https://www.myaadenetwork.org/p/cm/ld/&fid=7174 🙌

@WellAheadLA @WellAheadLA · Apr 8
Focusing on the fight against #HeartDisease and #stroke is one of the best ways you can make a difference in your #community. Here's how! ❤️❤️❤️
#HealthyHearts #BeALeader



1 4 42

Well-Ahead Louisiana
Published by Hillary Simpson Sutton [?] · April 19 at 10:00am ·

The trick to staying healthy with high blood pressure is monitoring your salt intake. When grocery shopping, choose low-sodium or no salt added options.

Well-Ahead Louisiana
402 followers
3w

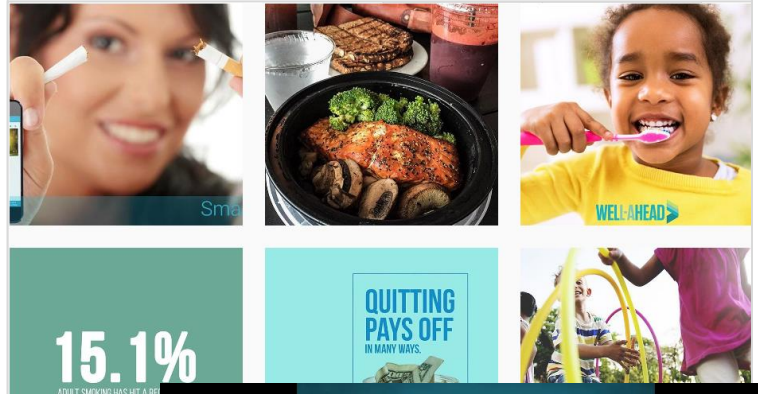
Providers -- Help your patients quit tobacco! 🚭 In less than three minutes, you can complete our brief Tobacco Intervention Provider Training course online. Learn more: http://bit.ly/2xxYE9T

#HealthyAir

wellaheadlouisiana Edit Profile

174 posts 534 followers 421 following

WellAheadLouisiana Well-Ahead Louisiana encourages people & groups to make small healthy lifestyle changes so we can all enjoy our great state for many years to come. www.facebook.com/WellAheadLA



Quality Insights, Quality Innovation Network

DEBRA RUSHING, RN, MBA
Cardiac, Louisiana State Lead

Million Hearts®

Quality Insights

Partnering With Quality Insights Quality Innovation Network

Debra Rushing, RN, MBA
Medicare Projects Director

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

Quality Insights

The QIN-QIO Program's Approach to Clinical Quality

Aims

Foundational Principles

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

- **Make care safer**
- **Strengthen person and family engagement**
- **Promote effective communication and coordination of care**
- **Promote effective prevention and treatment**
- **Promote best practices**
- **Make care affordable**

Four Key Roles of QIN-QIOs

- Facilitate Learning and Action Networks (LANs)
  - Creating an “all teach, all learn” environment
- Teach and advise as technical experts
  - Teach so learning is never lost
- Champion local-level, results-oriented change
  - Improve data
  - Active engagement of patients; convene community partners
  - Spread innovation and best practices that “stick”
- Communicate effectively
  - Sustain clinician, provider and patient/family behavior change

CMS 2014-2019 Medicare Quality Improvement Projects

- Cardiovascular Health
- Nursing Home Quality
- Quality Reporting and Payment Programs
- Readmissions
- Adult Immunizations
- Palliative Care and Hospice Referrals for Heart Failure Patients
- Quality Improvement in LTACHs
- Transforming Clinical Practice
- Antibiotic Stewardship
- Preventing Adverse Drug Events
- Everyone with Diabetes Counts
- Opioids
- Annual Wellness Visit

Hypertension focus

- Cardiovascular Health
- Directives - Stroke prevention, HTN and smoking cessation
- Promoted Million Hearts website, best practices, resources
- Encouraged/increased use of BP protocols in practices and HHAs
- Promoted use of HHQI's cardiovascular data registry in home health setting
- Developed/promoted Quality Insights resources specific to stroke & BP
- Innovative resource distribution to beneficiaries through food commodity boxes in rural areas, Meals on Wheels

Hypertension focus

Diabetes Self Management Program

- Taught DEEP curriculum that included:
  - Cardiac overview
  - BP normal and HTN parameters
  - Nutrition and exercise effects on BP
  - Proper BP cuff placement
  - Tips for BP home readings, monitoring, reporting
  - When to call your health care provider
  - Medication adherence and reconciliation

CMS Medicare Quality Improvement Projects on the Horizon

5 Broad Aims

1. Improve Behavioral Health Outcomes, focusing on Decreased Opioid Misuse:
   - Decrease opioid related deaths and adverse drug events by 7% nationally
   - Decrease opioid prescribing for Rx >/90mme daily
   - Provide community education regarding HHS Opioid Strategies
2. Increase Patient Safety
   - Reduce ADEs in all settings by 6.5% nationally
   - Reduce ADEs in NH by 13% nationally

CMS Medicare Quality Improvement Projects on the Horizon

3. Increase Chronic Disease Self-Management
   - Cardiac and Vascular Health
   - Diabetes
   - Slowing and preventing ESRD
4. Increase Quality of Care Transitions
   - Decrease ED super utilizers by 12.24%
5. Improve Nursing Home Quality
   - Reduce ADE by 15.2%
   - Improve mean total quality scores by 11%

Questions

www.qualityinsights-qin.org

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

Quality
Insights

American Heart Association Hypertension Initiatives

ASHLEY HEBERT, MPA

Government Relations Director
Louisiana

CORETTA LAGARDE

Vice President,
Health Strategies
Louisiana

Million Hearts®

Programs and Resources that Align with Million Hearts

American Heart Association

Coretta LaGarde
Vice President, Health Strategies
Louisiana

Ashley Hebert
Director, Government Relations
Louisiana

American Heart Association®

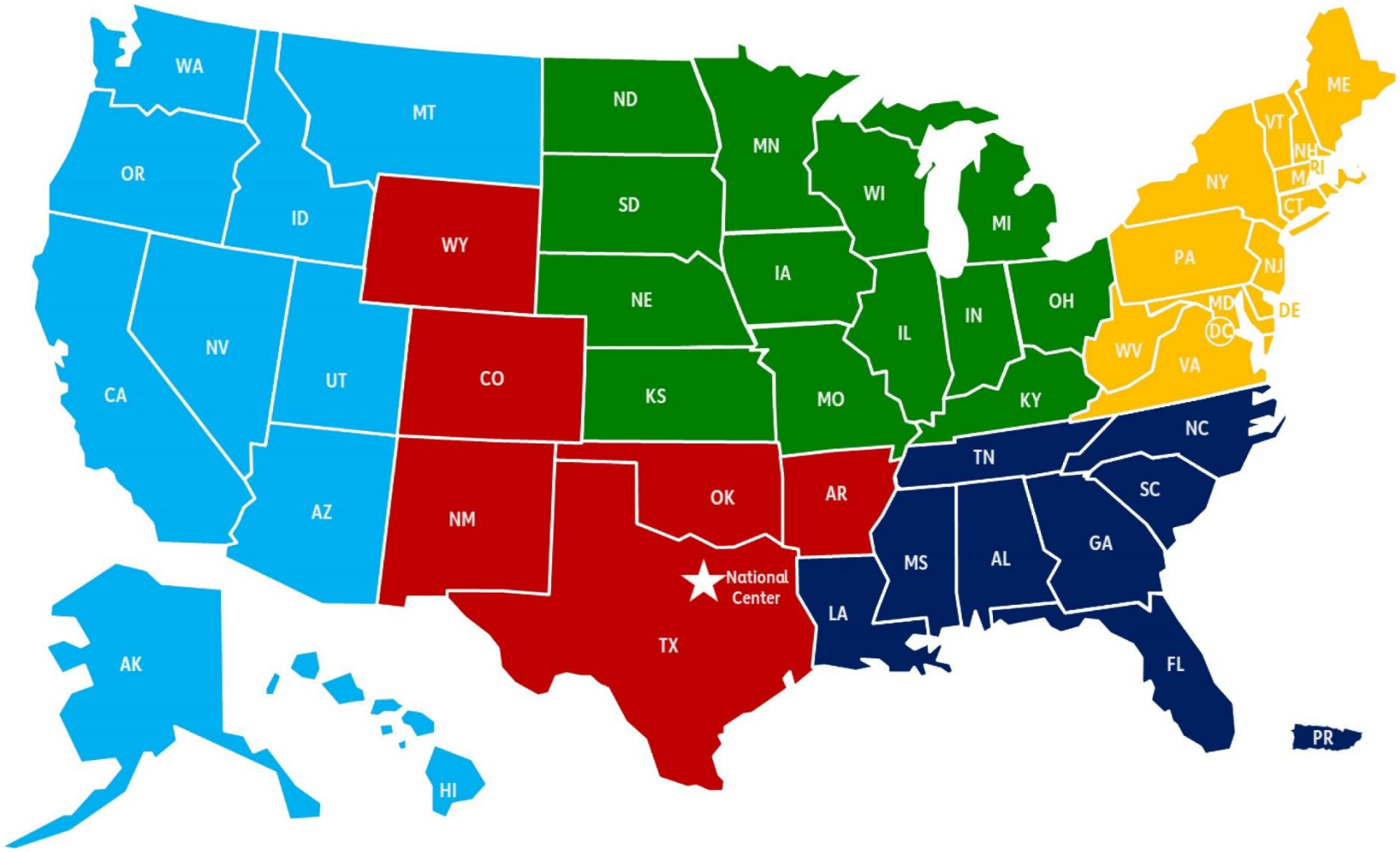
Who we are

The American Heart Association/ American Stroke Association is not just a charity. We are crusaders, innovators, scientists and partners.

Our Mission

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

Our levels of work



National – Dallas HQ

Education & awareness
Research management
Quality & science
Advocacy agenda
Strategic partnerships & alliances

5 regions

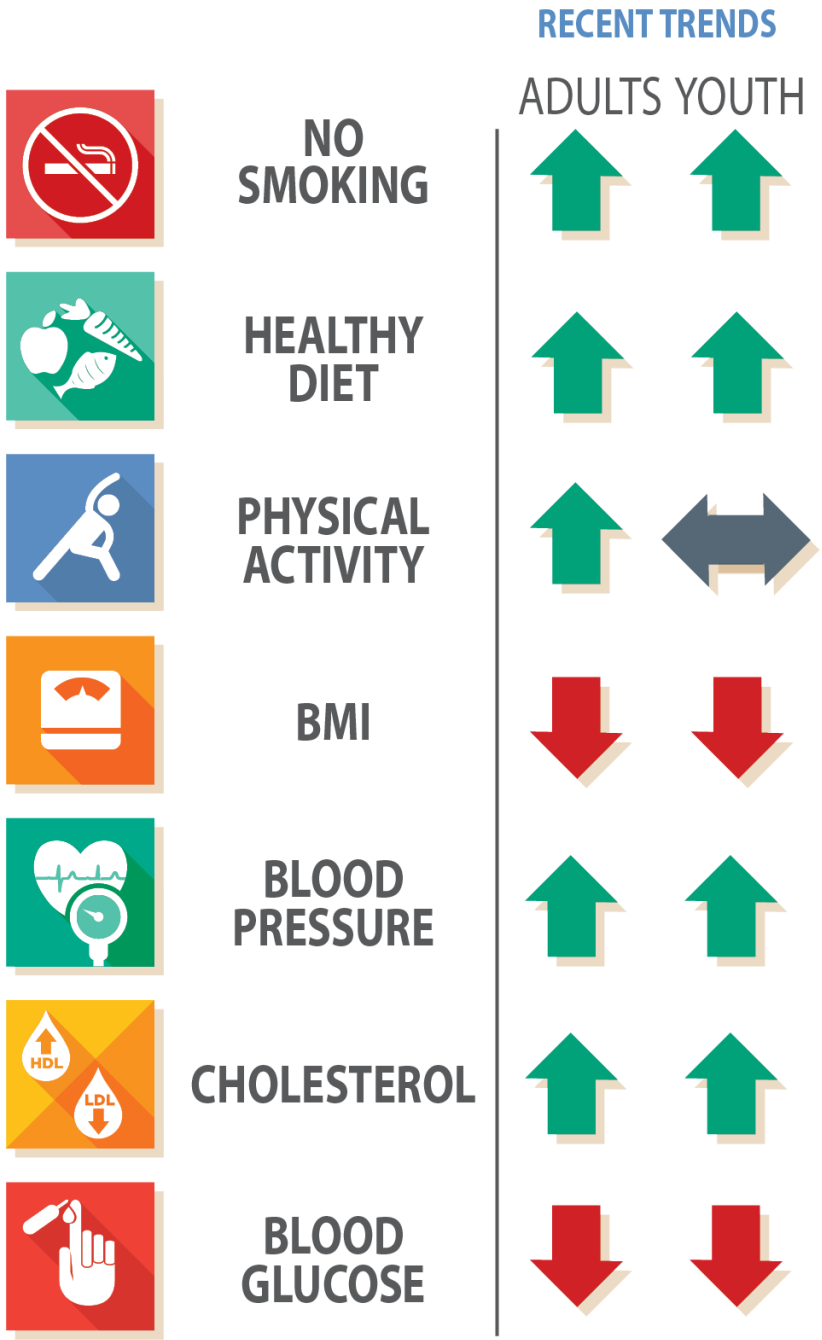
Activate advocacy
State and affiliate education
Quality improvement
Regional projects

Local

Grassroots advocacy
Fundraising & education
Building partnerships
Recruiting volunteers
Community health

Trends in health improvements

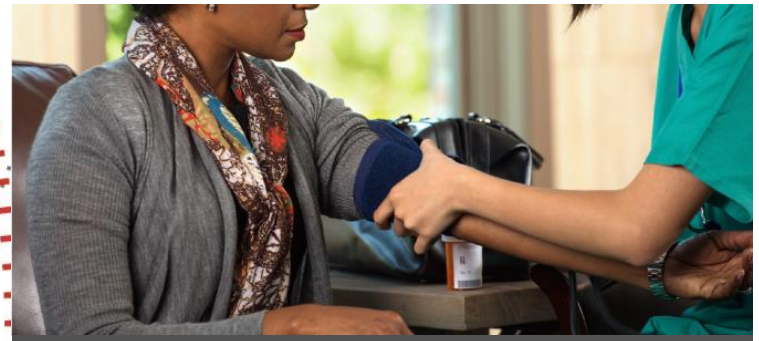
- Part of the 2020 impact goal is to improve health by 20% - and we're currently at 3.82%.
- In adults, we are seeing improvements in smoking rates, healthy diet, physical activity, blood pressure, cholesterol and blood pressure.
- In kids, we see improvements in smoking rates, healthy diet, blood pressure and cholesterol.
- Our work in these areas is being offset by issues such as BMI and blood glucose.



Compared to NHANES 2007-2008 (Baseline). NHANES (2015-2016) .

Building a culture of health in the community

Improving Health



Check. Change. *Control.* & Target: BP

Nearly 86 million
Americans have high blood pressure.

500,000 +
People have participated in Check. Change. *Control.* program to lower their blood pressure

Check. Change. *Control.* Cholesterol

40% of Americans have high cholesterol.

Our goal is to move
9 million
Americans to healthier cholesterol levels by 2020.

Heart-Check Mark

More than 900 products carry the Heart-Check mark

American Heart Association
CERTIFIED
Meets Criteria For Heart-Healthy Food

Know Diabetes By Heart

We're working alongside the American Diabetes Association and others to combat the growing threats from diabetes and cardiovascular diseases.

30 million American adults
have diabetes, including 7.2 million who are undiagnosed.

Cardiovascular disease is the
leading cause of death
For people living with type 2 diabetes.

Spotlight on Louisiana

Get with the Guidelines & Mission: Lifeline Quality Awards

LOUISIANA

Children's Hospital, **New Orleans**
Christus Schumpert Medical Center, **Shreveport**
East Jefferson General Hospital, **Metairie**
Lakeview Regional Medical Center, a campus of Tulane Medical Center, **Covington**
Ochsner LSU Health Shreveport, **Shreveport**
Ochsner Medical Center - Kenner, **Kenner**
Ochsner Medical Center - New Orleans, **New Orleans**
Our Lady of Lourdes Regional Medical Center, **Lafayette**
Our Lady of the Lake Regional Medical Center, **Baton Rouge**
Rapides Regional Medical Center, **Alexandria** *
Slidell Memorial Hospital, **Slidell**
St. Charles Parish Hospital, **Luling**
St. Francis Medical Center, **Monroe**
St. Tammany Parish Hospital, **Covington**
Terrebonne General Medical Center, **Houma**
Touro Infirmary, **New Orleans**
Tulane University Hospital and Clinic, **New Orleans**
University Medical Center New Orleans (UMCNO), **New Orleans**
West Jefferson Medical Center, **Marrero**
Willis-Knighton Pierremont Health Center, **Shreveport**

Key to the Awards

American Heart Association. Get With The Guidelines. Stroke
American Heart Association. Get With The Guidelines. Heart Failure
American Heart Association. Get With The Guidelines. Resuscitation
American Heart Association. Get With The Guidelines. AFib
American Heart Association. Get With The Guidelines. Coronary Artery Disease

Gold Achievement
These hospitals are recognized for two or more consecutive calendar years of 85% or higher adherence on all achievement measures applicable to each program.

Silver Achievement
These hospitals are recognized for one calendar year of 85% or higher adherence on all achievement measures applicable to each program.

Gold Plus Achievement
These hospitals are recognized for two or more consecutive calendar years of 85% or higher adherence on all achievement measures applicable and 75% or higher adherence with additional select quality measures in heart failure, stroke and/or resuscitation.

Silver Plus Achievement
These hospitals are recognized for one calendar year of 85% or higher adherence on all achievement measures applicable and 75% or higher adherence with additional select quality measures in heart failure, stroke and/or resuscitation.

*These hospitals received Get With The Guidelines-Resuscitation awards from the American Heart Association for two or more patient populations.

American Heart Association.

You're the Cure – Advocacy

Through our advocacy efforts:

3.8 million	babies are screened for congenital heart defects.
210 million	Americans live in smoke-free communities.
2.5 million	students are trained in CPR every year.

Local Priorities

- Complete Streets
- Healthy Restaurant Kids' Meals
- Smoke-Free

Spotlight on Louisiana

Advocacy – Policy Priorities in Louisiana

Healthy Eating / Active Living

- Support efforts to increase active living and healthy eating through policy

Tobacco Free

- Support efforts to decrease tobacco use in Louisiana

American Heart Association®

State Campaigns

Healthy Restaurant Kids' Meals: Sugary drinks are the single largest source of added sugars consumed by people living in the United States. Sugary drinks may increase the risk of hypertension and heart disease, independent of weight gain. Increasing sugary drink consumption by one serving per day can increase a person's risk of hypertension by eight percent and risk of heart disease by 17 percent.

The American Heart Association will be leading a policy effort to make milk or water the default beverage in all kids' meals in Louisiana.

American Heart Association®

Local Campaigns

New Orleans Complete Streets: The New Orleans Complete Streets Coalition had a productive meeting with Mayor Cantrell and key members of her staff this week. Her team will provide a response to the Complete Streets policy recommendations we provided by September 1st. In addition, the Mayor will reconvene the Complete Streets Working Group meetings.

New Orleans Healthy Restaurant Kids' Meals: We met with City Council members and the City's Health Department in moving toward an ordinance that would provide for water and milk as the default beverage for kids' meals at local restaurants. We have a clear path forward for this policy, so stay tuned!

American Heart Association®

Local Campaigns

Smoke Free Shreveport: Stay tuned for an Advocacy training on comprehensive smoke-free policies, including common tobacco and casino industry tactics.

Smoke Free Lake Charles: The Coalition for a Tobacco-Free Louisiana (CTFLA) has begun grassroots activities in Lake Charles and kicked off the football season right with a smoke-free tailgate for the Southern University vs. McNeese game. Having volunteer-based support, especially from the business community, to push council members to consider a smoke free ordinance is imperative.

American Heart Association®

Tools and Resources

Online Tools

- AHA Louisiana Facebook Page
- Sign up for You're the Cure; http://www.yourethecure.org
- My Life Check
- Heart Attack Risk Calculator
- AHA's Smoking Cessation Tools and Resources
- AHA's Workplace Health Solutions

Resources

- EmPowered to Serve
- Get With The Guidelines; www.heart.org/quality
- Target: BP
- Check. Change. Control. Cholesterol.
- Know Diabetes By Heart

American Heart Association.

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?

American Heart Association.

Contact Information

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Ashley Hebert
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Break

Resume at 10:45 am

Million Hearts®

Louisiana Partner Hypertension Initiatives

Million Hearts®

Partnering with Providers to Implement Sustainable Systems Changes

KENNY J COLE, MD, MHCDS

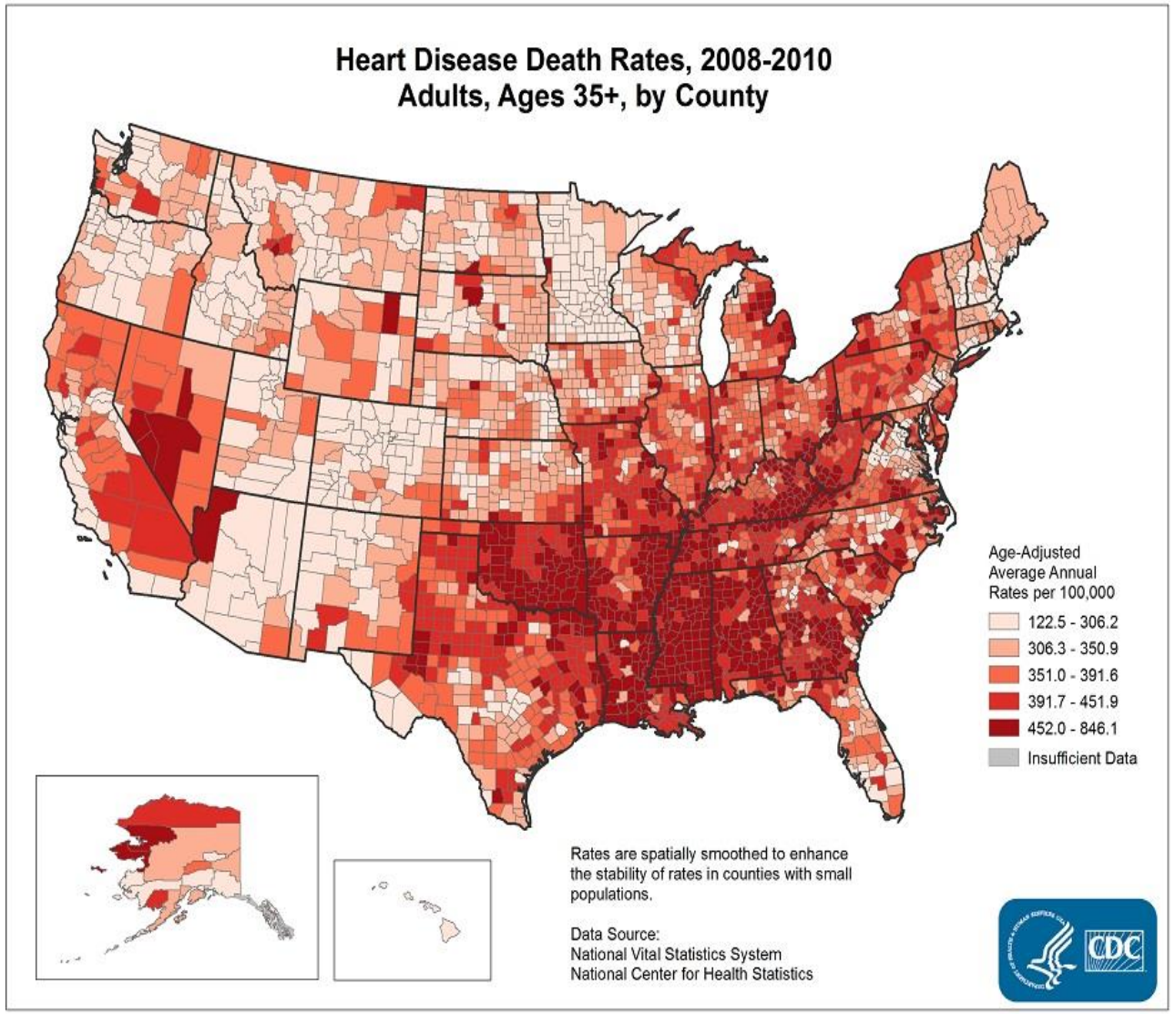
System VP, Clinical Improvement

Ochsner Health System

Million Hearts®

Life in Louisiana

Louisiana's Cardiovascular Crisis



Measure Up
Pressure Down

- ***Measurable improvements*** **in high blood pressure prevention, detection, and control**
  - **80% of patients at goal according to JNCVII**
  - **75% of AMGA membership adopt (at least one) campaign planks**

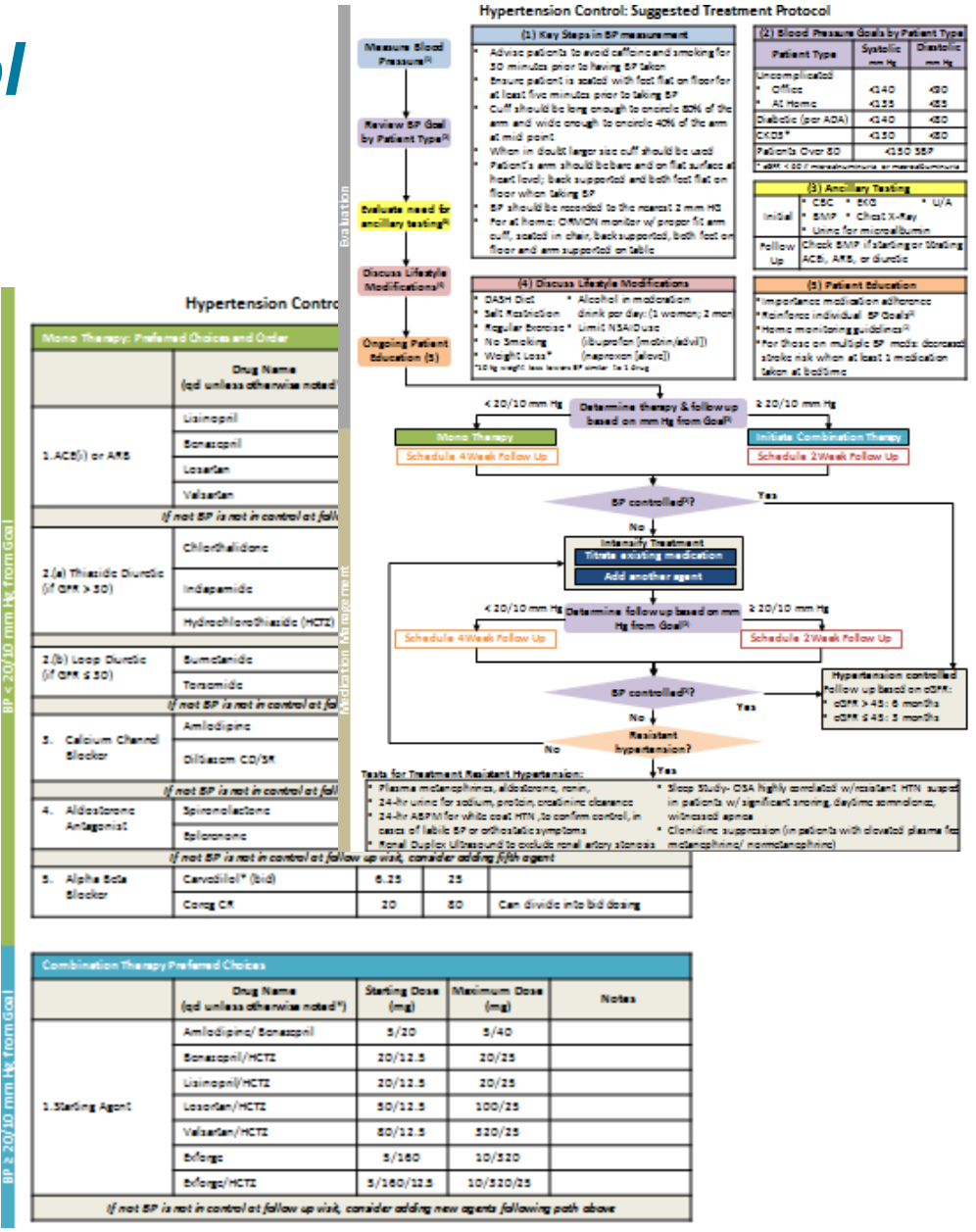
- ***Engage and empower patients*** **to actively manage their health.**

AMGA AMGF

80% of Patients at Goal Blood Pressure

Evidence-Based Protocol

- **Includes key steps in measurement, goals, ancillary testing, life style modifications, and patient engagement strategies**
- **Flows pathway for medication prescription and follow up visits based on how far BP is out of control**
- **Identifies additional tests for treatment resistant hypertension**
- **Lists drug names, dosages, and notes by mediation category for both mono therapy and combination therapy**



Registry of Uncontrolled Patients

MD #25 Electronic Medical Record				October 20, 2014
Patient Name	Date of Last Visit	BP at last visit	Return Visit Scheduled Date	Note
Joe Smith	10/1/14	150/ 90	10/27/14	
Jane Doe	10/15/14	166/ 102	10/29/14	
Mary Jane	10/2/14	162/ 94	10/16/14	Nurse Kim has left two message trying to contact patient
Pat James	10/11/14	144/ 83	10/31/14	BP is improving. Can return for nurses visit.

- Utilized EMR to automatically add patients whose BP is out of control
- Monitored daily by physicians and nursing staff to ensure all patients have been scheduled for follow up visits
- Allowed for staff to add notes about problems with engaging patients
- Highlighted patients in need of attention

Nursing Telephonic Outreach for Patient Engagement

- **Utilized registry to contact patients about scheduling follow up visits**
- **Fostered patient engagement by reminding them of the importance of getting BP under control**
- **Allowed patients to return for a nurse visit to measure BP, avoiding costly copays**

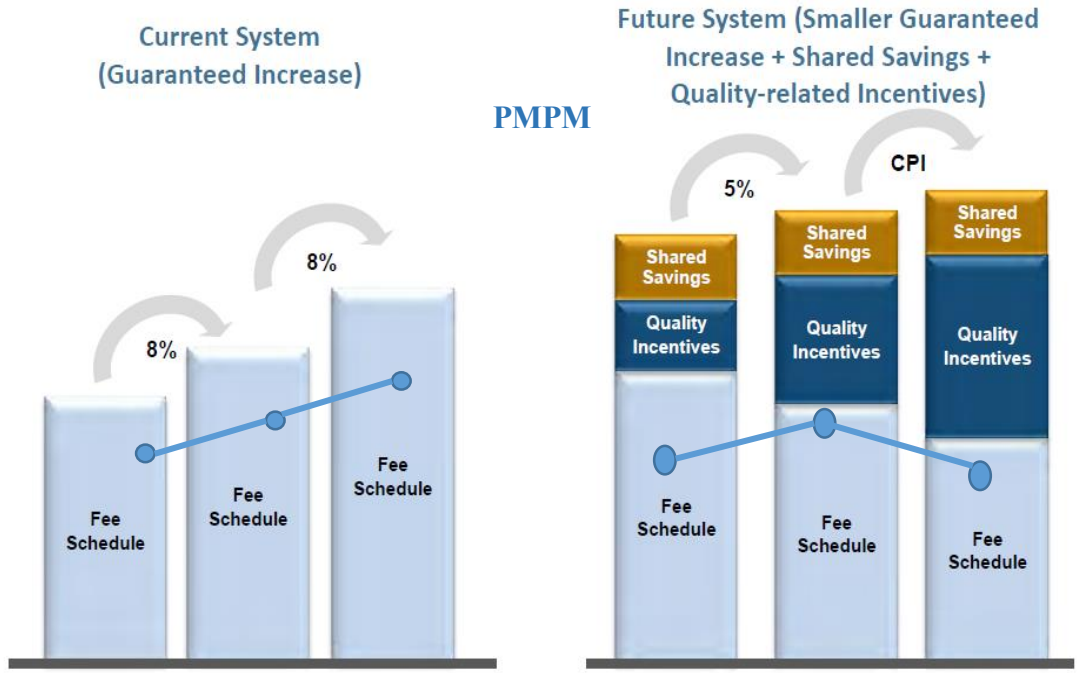
Quality Blue Primary Care

Traditional Fee-for-Service provider Reimbursement → Value Based Reimbursement

- Incentivizes collaboration among providers, patients and employers
- Everyone has “skin in the game” and is motivated to improve health outcomes and lower costs
- The key is…… getting providers and health systems engaged and focused on efficiency, appropriateness and excellent clinical outcomes.

Care Delivery Innovation: *Value-Based Payment*

Innovative payment strategies gradually shift accountability for quality outcomes and cost onto provider



Initial Clinical Outcomes Measures

Optimal Diabetes Care

- Blood sugar control
- Cholesterol control
- BP control
- Non-smoker

Optimal Vascular Care

- Cholesterol control
- BP control
- Non-smoker
- Aspirin

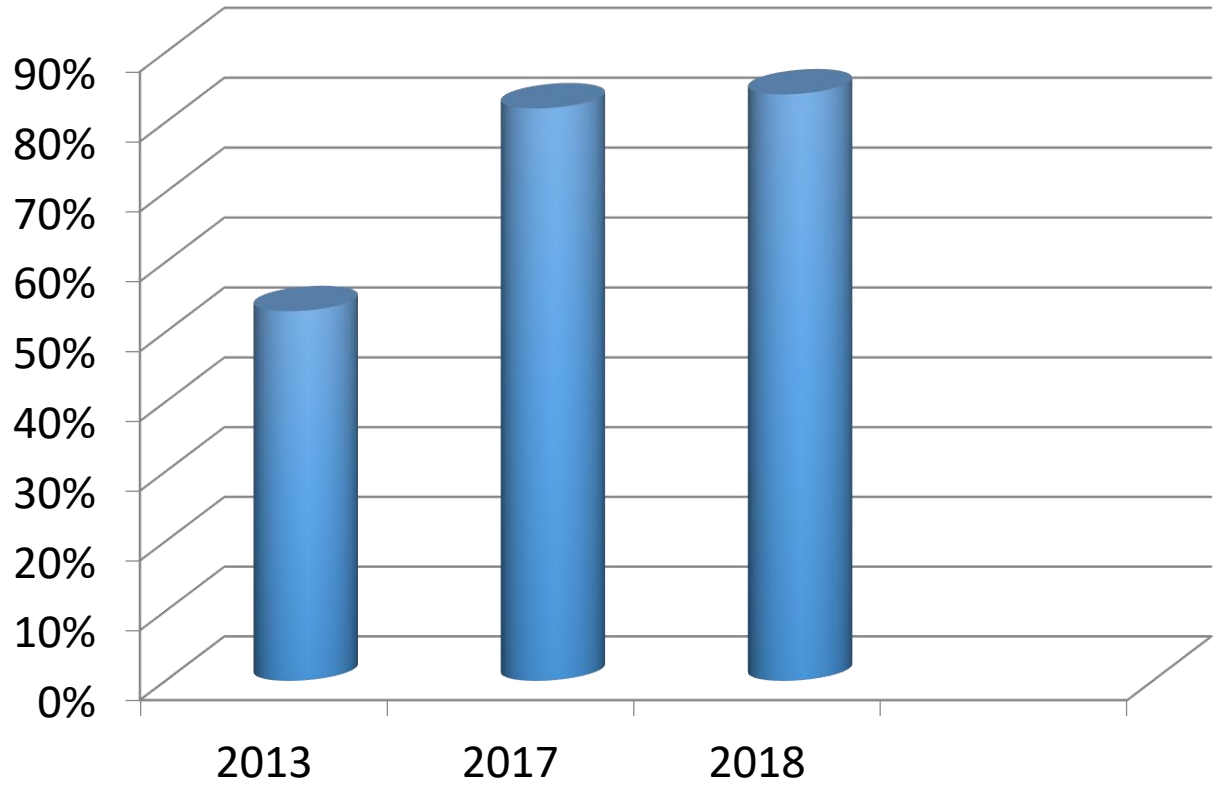
Optimal CKD Care

- BP control
- Cholesterol control
- Use of class of medication known to protect kidneys

Healthier Patients

BP control

Rates of Hypertension Control



Bogalusa Heart Study and Hypertension

CAMILO FERNANDEZ ALONSO, MD MS

Department of Epidemiology, Center for Cardiovascular Health

Tulane University School of Public Health and Tropical Medicine

New Orleans, Louisiana

Million Hearts®

Tulane University

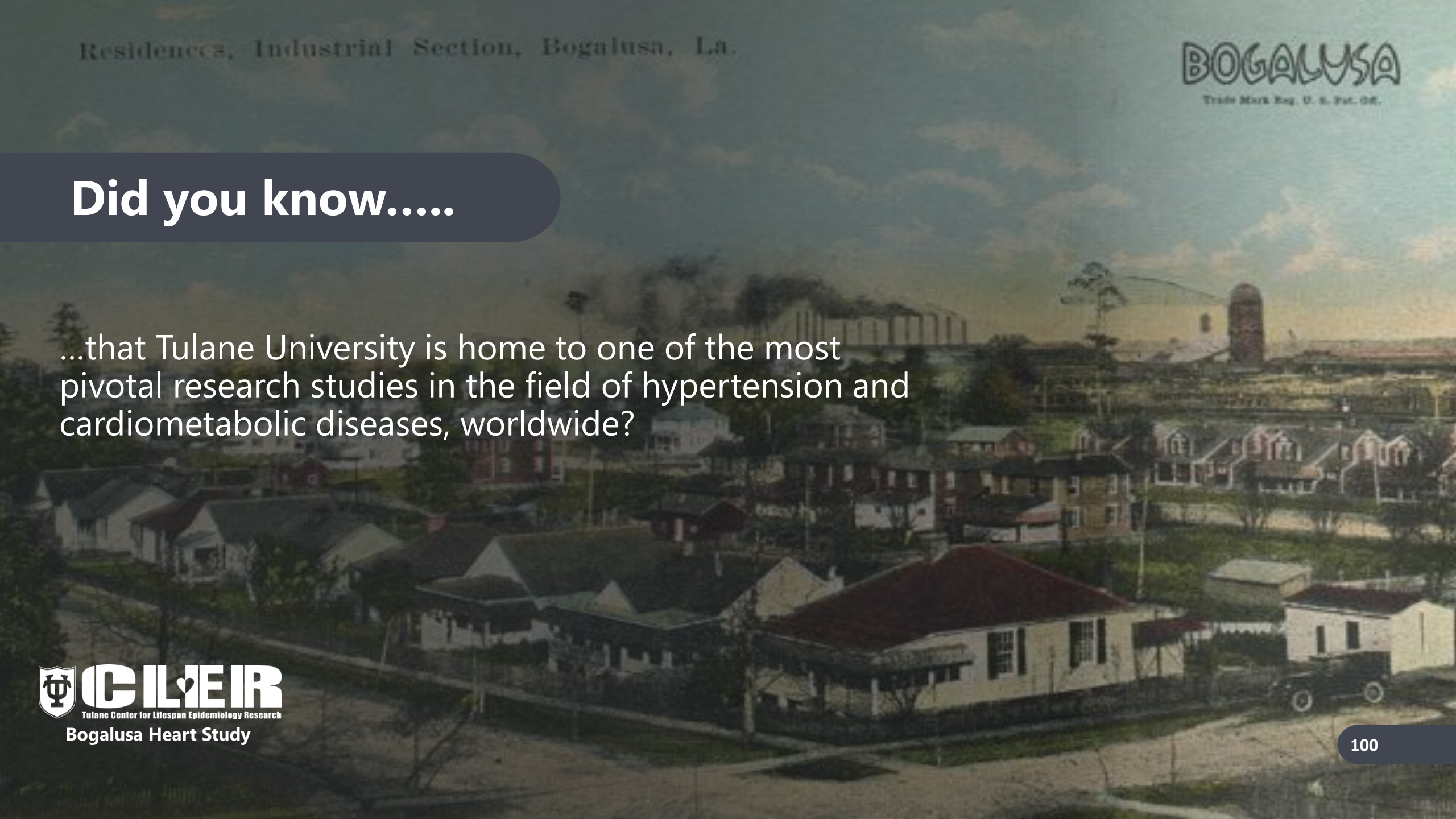
THE **BOGALUSA HEART** STUDY

+40 Years of **Hypertension** and **Cardiovascular Disease** Research

Presented by:

Camilo **Fernandez**, MD, MSc, MBA

Senior Research Scientist | Cardiovascular Disease
Center for Lifespan Epidemiology Research
Tulane University School of Public Health and Tropical Medicine



Did you know.....

...that Tulane University is home to one of the most pivotal research studies in the field of hypertension and cardiometabolic diseases, worldwide?

The Bogalusa Heart Study

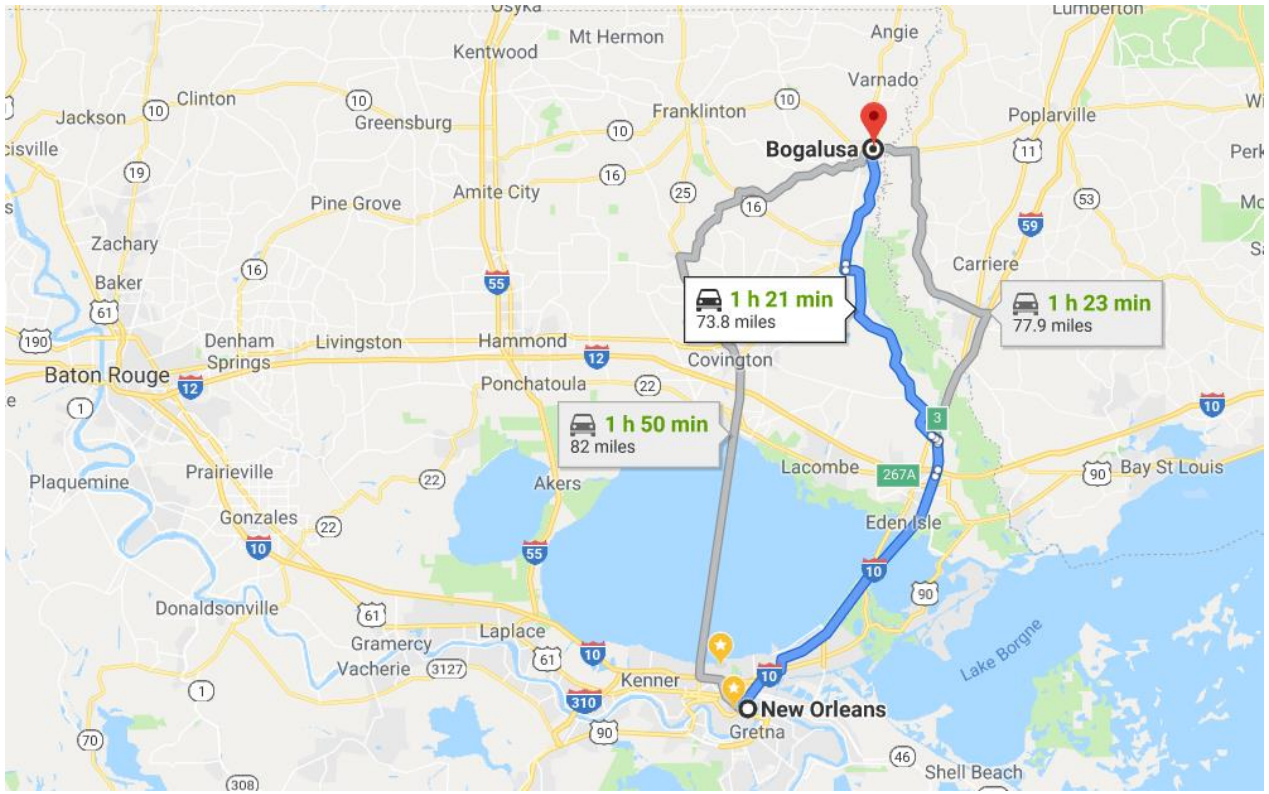
One of the longest on-going studies of a biracial, semi-rural community in the Southern US. Our focus is on understanding the impact of cardiovascular and metabolic changes on health throughout the lifespan.

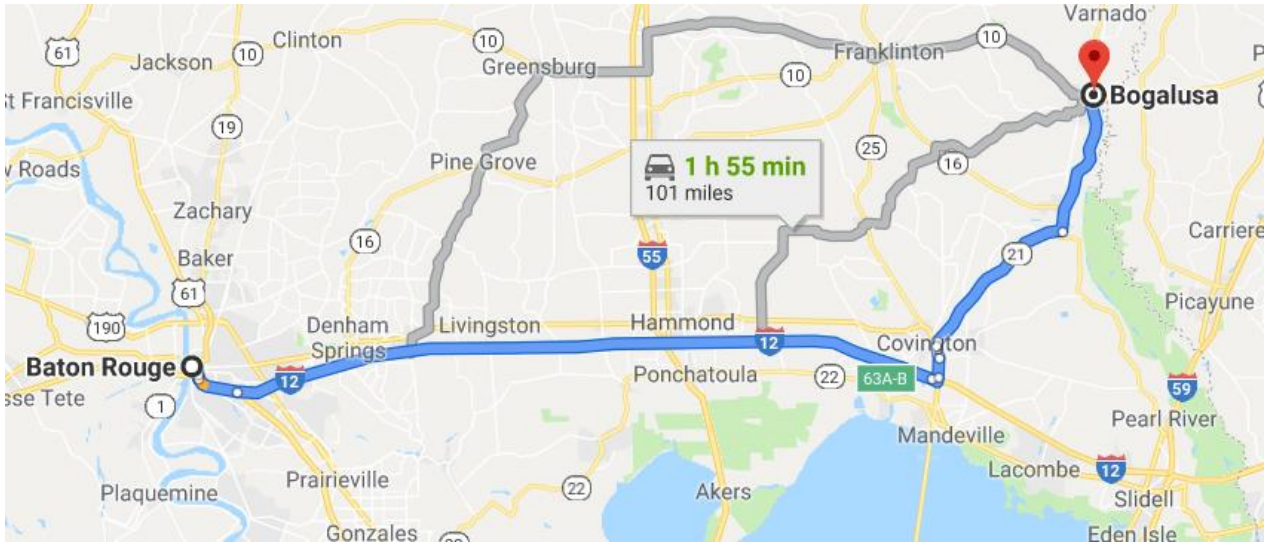
170+ studies/sub-studies have been conducted over the years, which include special studies on socioeconomic evaluations, **blood pressure studies**, a lipids study, genetic/epi-genetic studies, exercise, heart murmur studies, newborn cohort, diabetes, pathology, and CV imaging

More than 1,000 publications, five textbooks and numerous monographs have been produced describing observations on more than 12,000 children and adults in Bogalusa, Louisiana.

BOGALUSA, LOUISIANA

BOGALUSA HEART STUDY
Since 1973





The Bogalusa Heart Study History | Timeline

+40 years of Health Disparities Research

Establishment

1972, Franklinton pilot study

Special Lipid Studies

1977

Autopsies

1978

EKG Studies

1981

First Family Studies/ Genetic Studies

1982

Ambulatory Blood Pressure

1988

1972-74

1975-78

1980-88

PUNCH CARD

COMPUTER

Dietary Studies

1976

Initial Dietary Recalls

SCOR-A

Only 2 centers were awarded by the NIH—one of them was Bogalusa

1973, The Bogalusa Heart Study began

Blood Pressure Studies, High School Follow-ups

1975

ECHOCARDIOGRAM

1981

DENTAL STUDIES

1987

3-18 age of population

19-32 age of population

The Bogalusa Heart Study History | Timeline

+40 years of Health Disparities Research

Post High School Follow-ups
1992-1996

ECHOCARDIOGRAPHIC FOLLOW-UPS
CAROTID ULTRASOUND
1998

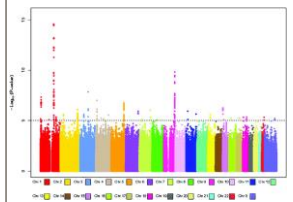
EVOLUTION OF CARDIOVASCULAR RISK WITH NORMAL AGING STUDIES

Genetic/Genomic Association Studies

ECHOCARDIOGRAM
CAROTID ULTRASOUND
NON-INVASIVE VASCULAR STUDIES

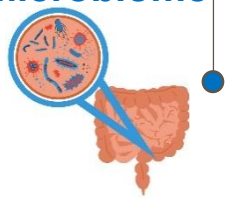
Cognitive / Physical Function

MRI / PET



Epigenetics

Microbiome



1992-99 | 2001-10 | 2013-

19-35 age of population

36-55 age of population

Major Findings by Decade - When the study began, there was almost NO information on heart disease risk factors (blood pressure, body weight, cholesterol, blood sugar, etc.) in childhood, even though it was [already] the #1 cause of death in the US.

1970s

- The roots of heart disease start in childhood.
- Atherosclerosis (fatty streaks and aortic plaques) could be seen on autopsy in teenagers and young adults who died accidentally.

1980s

- Childhood levels of **blood pressure**, cholesterol, body weight, blood sugar and insulin resistance predict or "track" into young adulthood and might influence mid-life health.

1990s

- The more childhood risk factors seen (higher weight, blood pressure, cholesterol, etc.), the more CV structure/function alterations are observed on ultrasound imaging of the heart and blood vessels, even when there were absolutely no symptoms among young adults in their 20's to 30's.

Findings by Decade (cont´d)

2000s

- Weight at birth impacts atherosclerosis burden in mid-life (30's to 40's). This indicates that the roots of heart disease go back even into time during pregnancy, time *in utero*.
- Telomere length (i.e. the end cap of chromosomes) was different by age, sex, race and heart disease risk factors, suggesting that overall aging processes can be influenced by these.

2010s

- Across race-sex groups, puberty and young adulthood there are critical periods for development of **high blood pressure** later in life.
- Genes influence heart disease risk factors like body weight and **blood pressure** from childhood into adulthood
- Gut microbiome is associated with hypertension and heart disease over the lifespan.
- Temporal relationship of blood pressure during childhood and adolescence with cardiovascular structure and function in adulthood.

Annals of Internal Medicine | CLINICAL GUIDELINE

Screening for Primary Hypertension in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement*

Virginia A. Moyer, MD, MPH, on behalf of the U.S. Preventive Services Task Force†

Description: Update of the 2003 U.S. Preventive Services Task Force (USPSTF) recommendation on screening for high blood pressure in children and adolescents.

Methods: The USPSTF reviewed the evidence on screening and diagnostic accuracy of screening tests for blood pressure in children and adolescents, the effectiveness and harms of treatment of screen-detected primary childhood hypertension, and the association of hypertension with markers of cardiovascular disease in childhood and adulthood.

Population: This recommendation applies to children and adolescents who do not have symptoms of hypertension.

Recommendation: The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for primary hypertension in asymptomatic children and adolescents to prevent subsequent cardiovascular disease in childhood or adulthood.

Ann Intern Med. 2013;159:613-619. www.annals.org

For author affiliation, see end of text.

* The article appeared simultaneously in *Annals of Internal Medicine* and *Pediatrics*. Readers who wish to cite the article should use the following citation: Moyer VA; U.S. Preventive Services Task Force. Screening for primary hypertension in children and adolescents: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med. 2013;159:613-9.

† For a list of USPSTF members, see the **Appendix** (available at www.annals.org).

This article was published online first at www.annals.org on 7 October 2013.

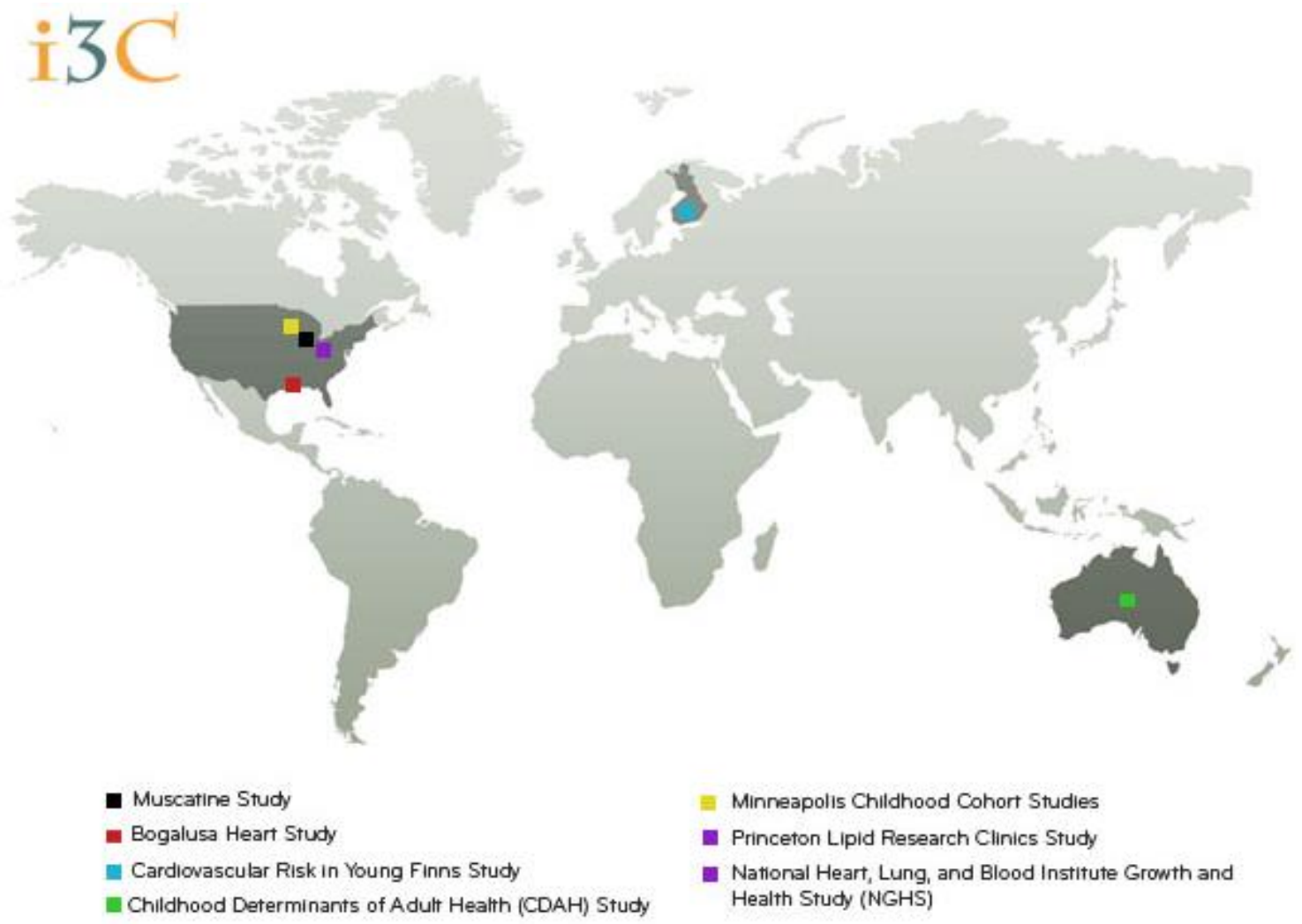
Evidence

We identified 10 studies that reported on the presence of hypertension (or elevated blood pressure) in children and the presence of hypertension or other intermediate outcomes in adulthood (**Table 3**, **Appendix B4**).[24, 46-54] We did not formally quality-rate these studies, though characteristics related to study quality are included in **Table 3**. Many of the studies had methodological shortcomings, making interpretation and direct comparisons of results difficult. In some studies, it was unclear if blood pressure thresholds in childhood were cohort-specific or based on standardized values.[24, 46, 49, 51, 52, 54] The definition of hypertension in childhood varied among the studies, with threshold values ranging from >80th percentile to >95th percentile, while three of the studies did not provide a definition of childhood hypertension.[47, 52, 54] The studies drew data from five cohorts: the Bogalusa Heart Study,[46, 49, 52, 54] the Muscatine Study,[51] the Fels Longitudinal Study,[24, 47] the Young Finns Study,[50, 53] and a cohort of children in Boston.[48] The studies reported either the association or diagnostic value of elevated childhood blood pressure in predicting hypertension,[24, 46-48, 50, 51, 54] carotid intima media thickness,[52, 53] or microalbuminuria[49] in adults.

National Reach

BOGALUSA HEART STUDY

Since 1973



Worldwide Reach

BROTHERS Program: Brothers Reaching Out to Help Educate on Routine Screenings

Church-based Intervention for eliminating CV Health Disparities in AA

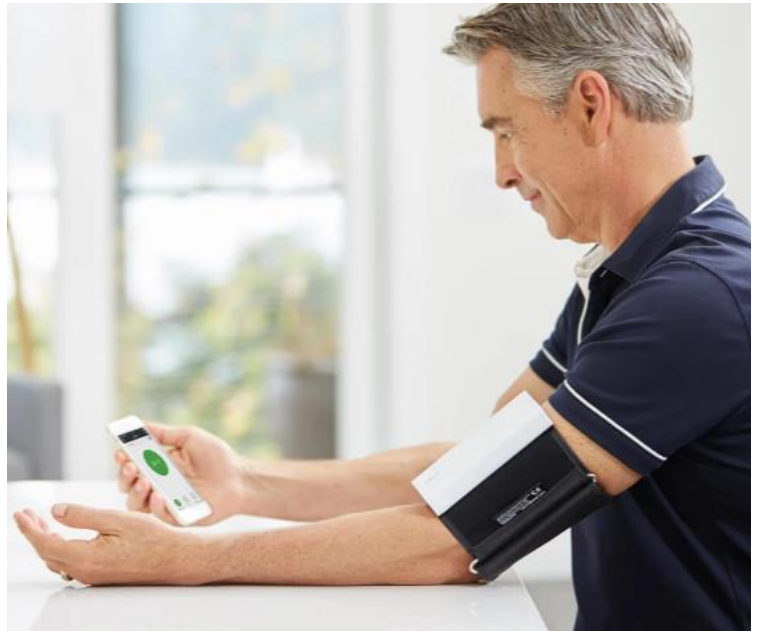
American Heart Association®
Heart Walk

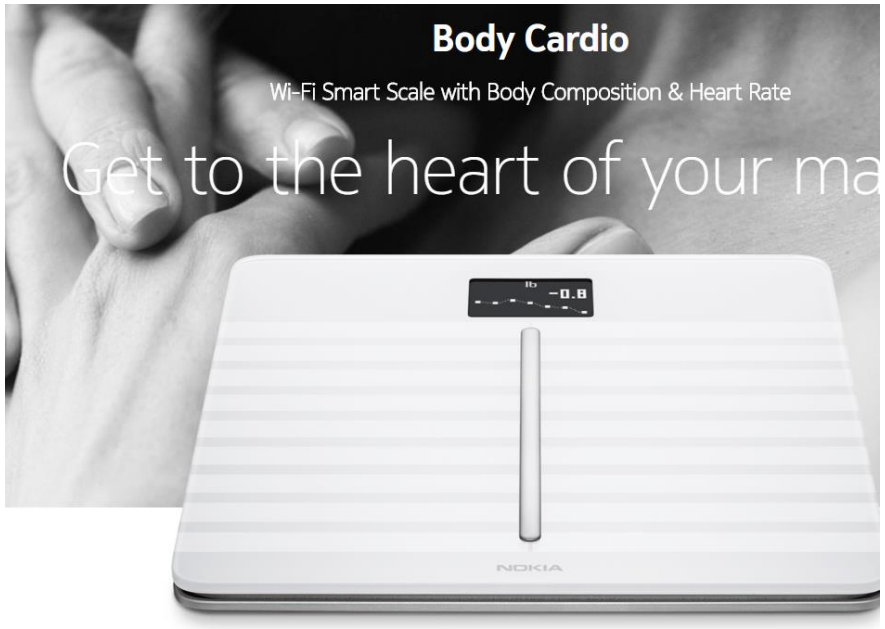
Active Presence in Community Activities

Health Ahead / Heart Smart Health Promotion Program - Schools

Blood Drives

Our Community





Virtual Clinic In-Home Procedures

Tulane Center for Lifespan Epidemiology Research

Questions | Collaboration

EMAIL:
cfernan1@tulane.edu

Camilo Fernandez, MD, MSc, MBA

OR

VISIT:
www.clersite.org

CALL:
(504) 988-7323

Louisiana Perinatal Quality Collaborative

VERONICA GILLISPIE-BELL, MD FACOG

Medical Director, Louisiana Perinatal Quality Collaborative
and Pregnancy Associated Mortality Review

Million Hearts®

Reducing Maternal Morbidity and Mortality in Louisiana: Addressing Severe Hypertension

Veronica Gillispie-Bell, MD, FACOG

Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review

Obstetrics & Gynecology

Objectives

- Long-term risks for hypertensive disorders in pregnancy
- Louisiana Maternal Mortality Report findings
- The Louisiana Perinatal Quality Collaborative (LaPQC)

Long-term effects of hypertensive disorders in pregnancy

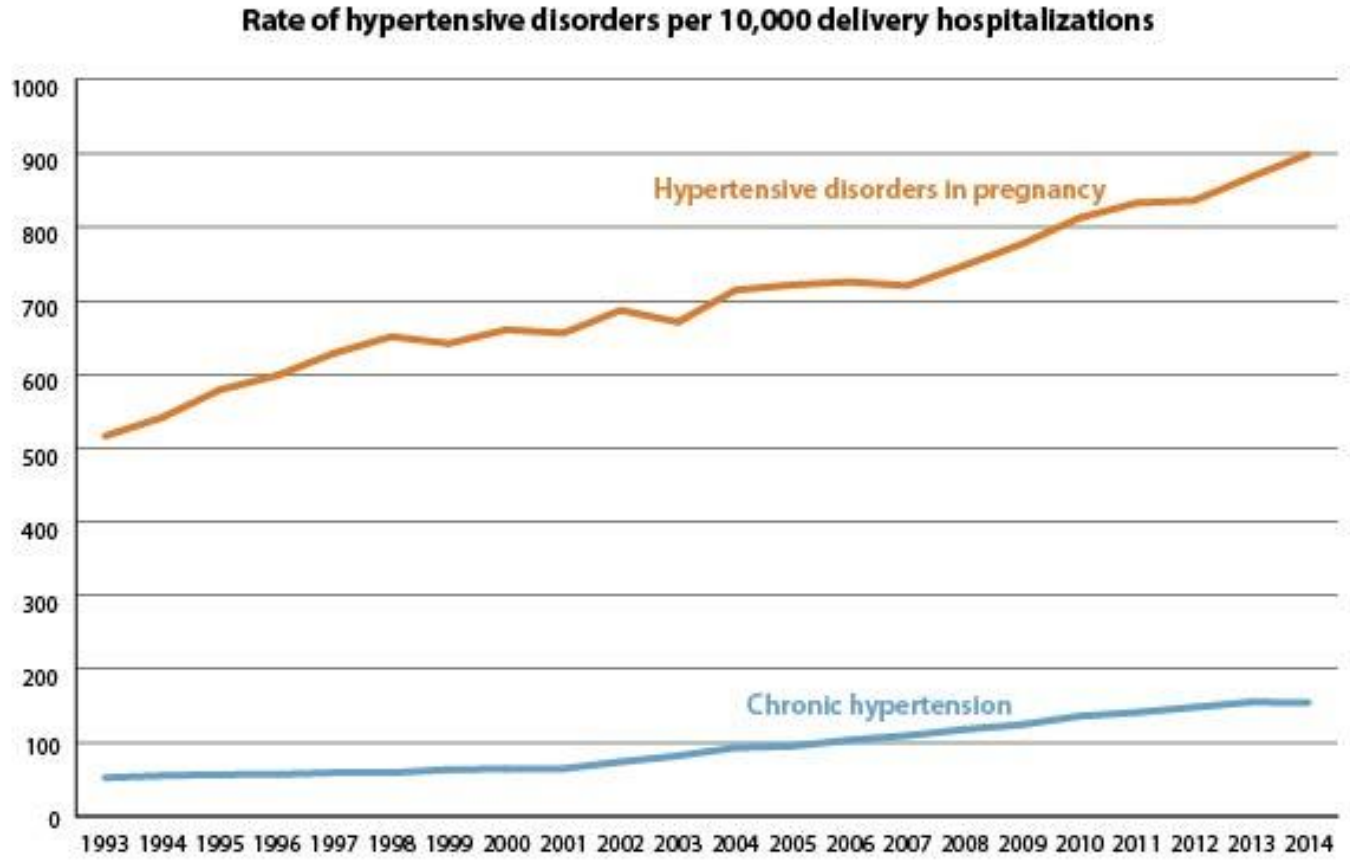
- Women who experience a hypertensive disorder in pregnancy have an increased risk of **cardiovascular disease, stroke, peripheral artery disease, cardiovascular mortality**

Long-term effects of hypertensive disorders in pregnancy

- **4 to 8 times** higher rate of cardiovascular disease in women with recurrent pre-eclampsia
- **2 times** the risk of cardiovascular disease
- **5 times** higher rate of hypertension

Hypertensive Disorders, 1993-2014

The rate of hypertensive disorders in pregnancy is rising at a rate higher than that of chronic hypertension.



*Data on Selected Pregnancy Complications in the United States. CDC.

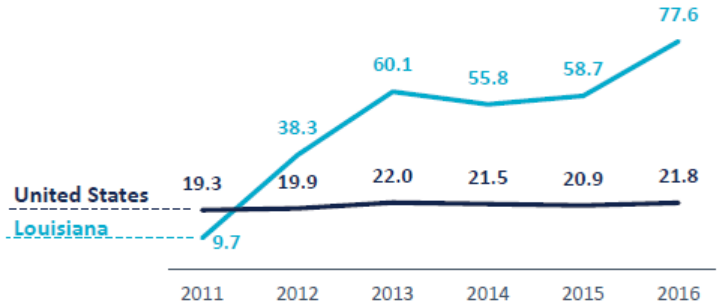
LOUISIANA MATERNAL MORTALITY REVIEW REPORT

2011-2016

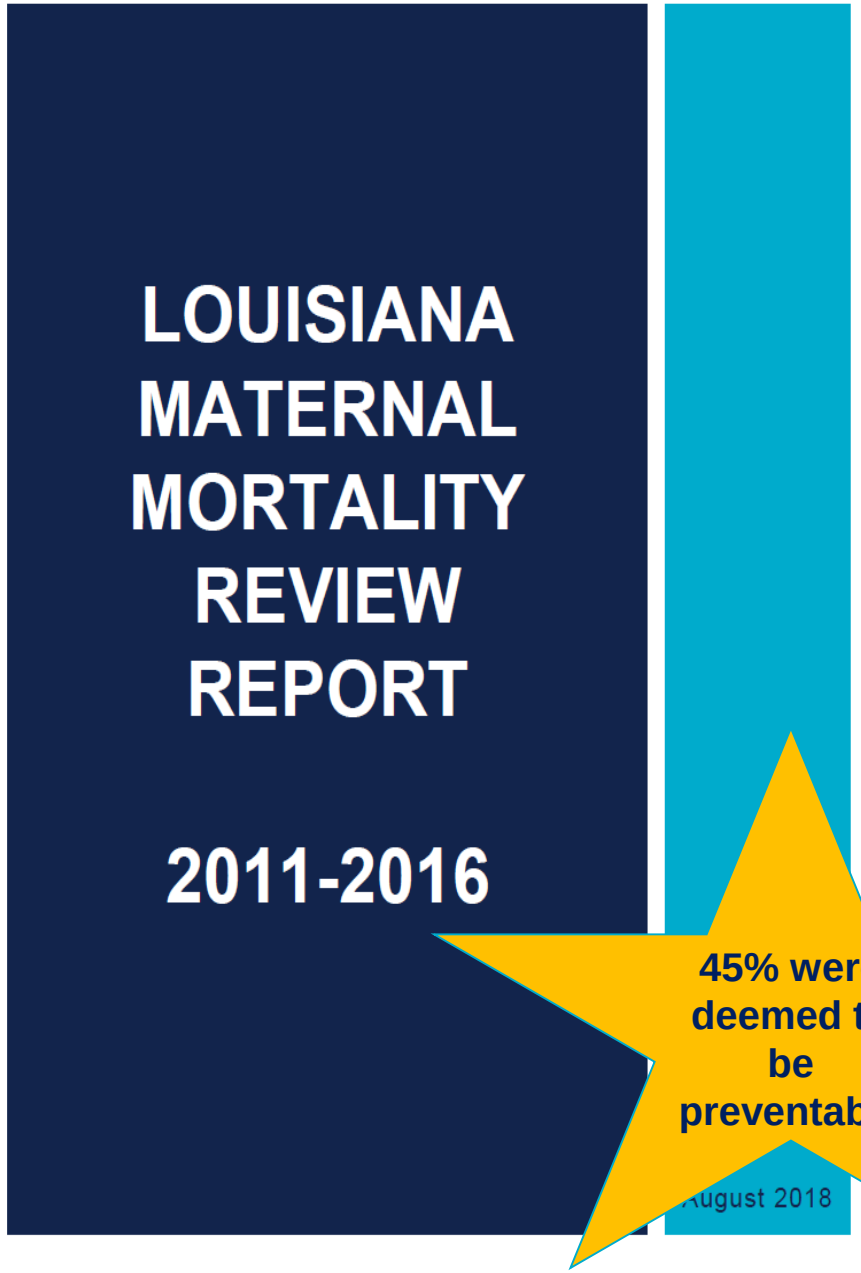
August 2018

KEY FINDINGS

- Maternal Mortality: a maternal death occurring within 42 days of termination of pregnancy[1]
- Between 2011-2016, maternal mortality rate increased by an average of 34% per year
  - 12.4 per 100,000 live births



Ref: Kieltyka L, Mehta P, Schoellmann K, Lake C. Louisiana Maternal Mortality Review Report 2011-2016. August 2018.



KEY FINDINGS

- **Leading case of death**
  - Hypertension related (cardiomyopathy, cardiovascular conditions, preeclampsia/eclampsia)
  - Hemorrhage

45% were deemed to be preventable

Altering Outcomes

The assessments of preventability and chance to alter outcomes help prioritize future areas of intervention and action.

National Findings

Based on data from review committees in 9 other states and cities:[8]

70% of deaths due to **hemorrhage** were thought to be **preventable**.

68.2% of deaths due to **cardiovascular/coronary conditions** were thought to be **preventable**.

66% of deaths **occurring within 42 days of pregnancy** were thought to be **preventable**.

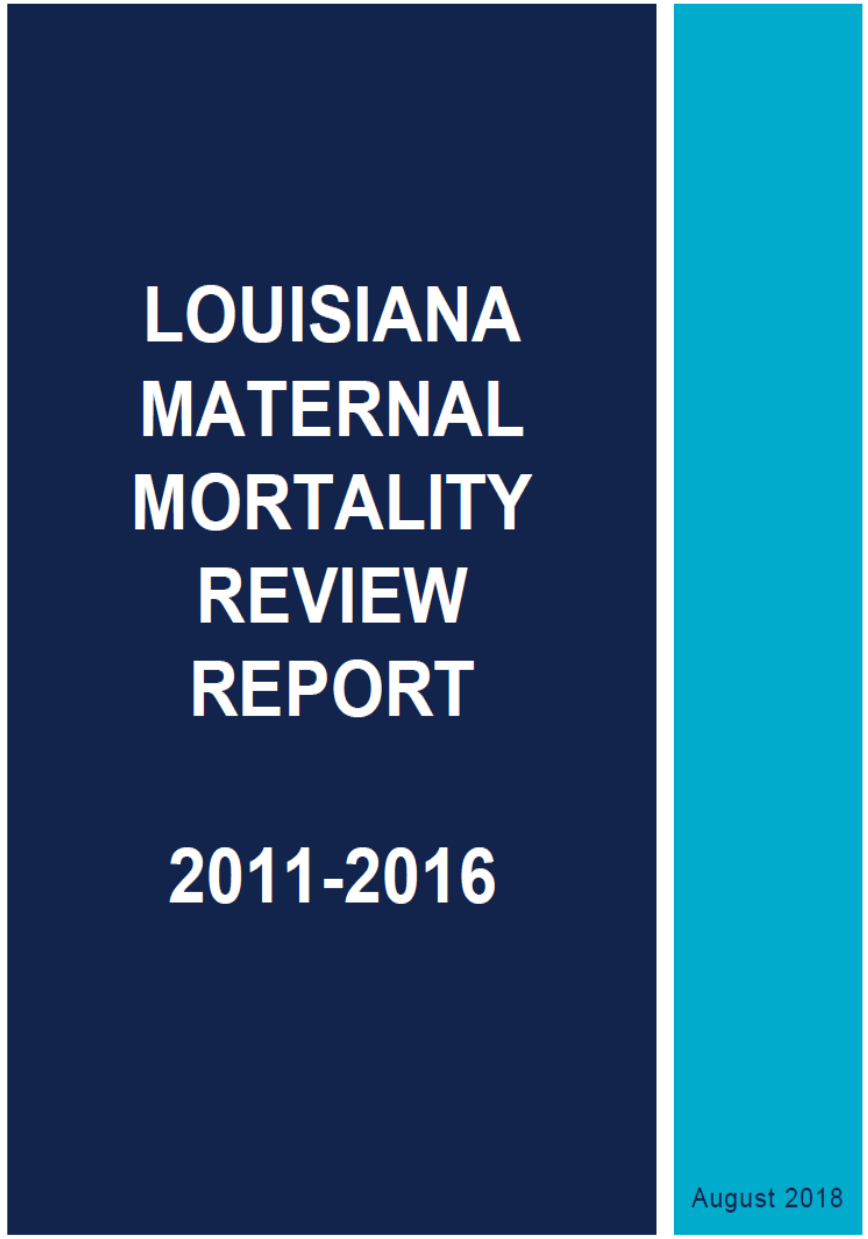
Louisiana Findings

62.5% of **hemorrhage** deaths were deemed **preventable**.

62.5% of **cardiomyopathy** deaths were deemed **preventable**.

40% of deaths due to **cardiovascular/ coronary conditions** were deemed **preventable**.

7 out of 8 deaths due to embolism, including thromboembolism and amniotic fluid embolism, were deemed **not preventable**.



KEY FINDINGS

- **Top Contributing Factors: Provider and Facility Level**
  - Failure to screen/inadequate assessment of risk – 36%
  - Lack of standardized policies and procedures – 13%
  - Lack of referral or consultation – 11%
  - Poor communication/lack of case coordination or continuity of care – 11%

LOUISIANA MATERNAL MORTALITY REVIEW REPORT

2011-2016

August 2018

KEY FINDINGS

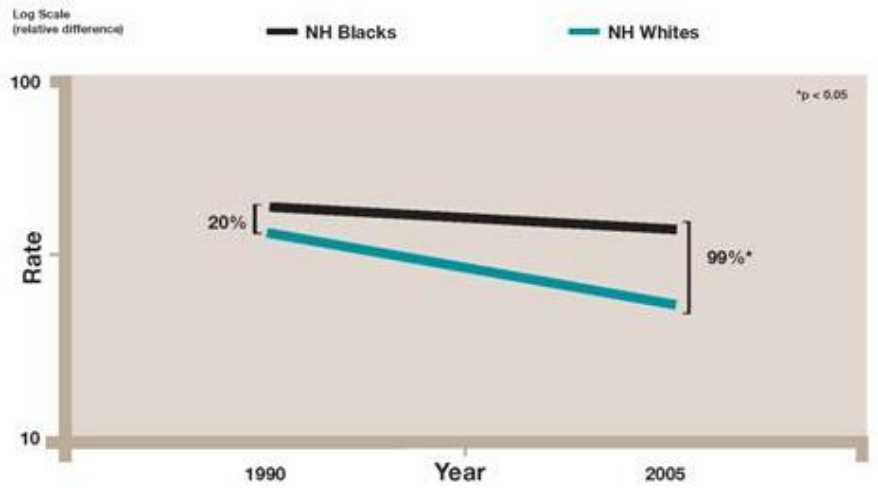
- **4** black women die for every **1** white woman
- Women age **35 years and older** were **6.3 times as likely to die** as women under age 25 years
- **62%** of women who died had **Medicaid** insurance.

Why do health disparities exist?

- **Implicit bias**
  - Implicit bias is unconscious judgment and/or behaviors that affect how we interact with others
  - Impacts patient-provider interactions, treatment decisions, treatment adherence and patient health outcomes[3]
  - https://implicit.harvard.edu/implicit/takeatest.html
- **Social determinants of health[4]**
  - Racial residential segregation[5]
  - Health care services
  - Socioeconomic status
  - Healthy behaviors

Change = Improvement + Equity

Breast Cancer Mortality Among Non-Hispanic Blacks and Non-Hispanic Whites in Chicago: 1990-2005



*Finding Answers: Solving Disparities through Payment and Delivery System Reform; solvingdisparities.org

Louisiana Perinatal Quality Collaborative (LaPQC)

- **What is the LaPQC?**
  - Formed in 2016, became an Initiative of Louisiana Commission on Perinatal Care and the Prevention of Infant Mortality in 2018.
  - A network of perinatal care providers, public health professionals and patient and community advocates who work to advance equity and improve outcomes for women, families, and newborns in Louisiana
    - Required for Level 3 and Level 4 Hospitals
    - 37 of 52 birthing facilities are participating

Louisiana Perinatal Quality Collaborative (LaPQC)

- **What is the goal of the LaPQC?**
  - Achieve a **20% reduction** in severe maternal morbidity among pregnant and postpartum women who experience **hemorrhage** or severe **hypertension/preeclampsia** in participating birth facilities by **Mother's Day 2020**
  - **Narrow** the **Black-white disparity** in this outcome

Louisiana Perinatal Quality Collaborative (LaPQC)

- **What does the LaPQC do?**
  - Facilitate collaborative learning opportunities through Learning Sessions and monthly calls
  - Identify and share best practices
  - Provide teams with a data portal to allow for real-time evaluation to guide decision-making
  - Provide subject-matter experts who are brought on as Faculty
  - Coordinate a guiding Advisory Committee
  - Ensure Louisiana's work is connected to national initiatives

LaPQC Change Package

Achieve a 20% reduction in severe maternal morbidity among pregnant /postpartum women who experience hemorrhage or severe HTN in LaPQC participating facilities

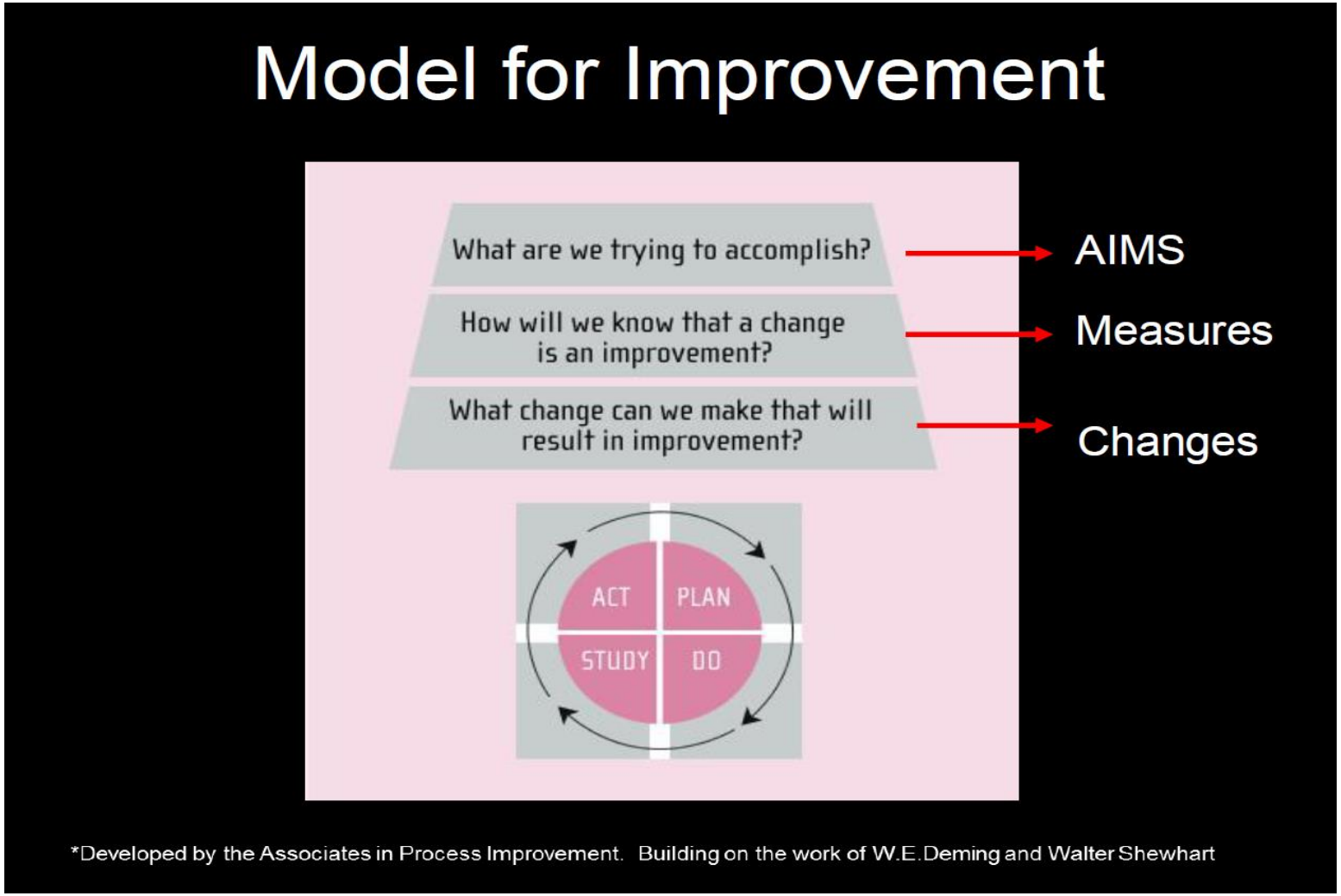
Narrow the Black-White disparity in this outcome

Reliable Clinical Processes	• Assure readiness • Improve recognition and prevention • Understand & reduce variation in response • Eliminate waste
Respectful Patient Partnership	• Design for partnership • Invest in improvement
Effective Peer Teamwork	• Reduce variation in reporting • Change the work environment • Improve work flow
Engaged Perinatal Leadership	• manage for quality & systems learning • enhance patient & family relationships • Change the work environment

Change Goals

- Make it easy to do the right thing
- Hardwire changes into routine practice
- All improvement is change, not all change is improvement
- Change structure, process, and culture
- Build measurement into processes, and learn where there are disparities

BTS: Model for Improvement



Hypertension in Pregnancy Toolkit

Alliance for Innovation on Maternal Health (AIM) a toolkit to improve maternal outcomes. There are four components:

Readiness

Recognition

Response

Reporting

Call to Action

- Learn from case reviews and debriefs to innovate
- Change the way physicians, midwives, nurses, patients, families communicate and work together (prenatal care, hospital discharge, ED)
- YOU can be a leader in the state
- Engage all providers and facility executives
  - Measure, report, and sustain positive change
- Communicate with urgency, act with optimism

Our Fundamental Agreements

- Re-center the work to the **who** and the **why**
  - with, not for or to
- Make care **equitable** by making care **better** and **consistent**
  - every woman, every time
- Change is **necessary**, change is **important**, change is **personal**

References

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Sankofa Community Development Corporation

DANELLE GUILLORY, MD, PHD

Healthy HeartBeats Program

Million Hearts®

Sankofa Community Development Corporation

Presentation Link...

Rural Health Center Hypertension Programs

COLLEEN ARCENEAUX, MPH

Population Health Manager
Well-Ahead Louisiana,
Louisiana Department of Health / Office of Public Health

Million Hearts®

Activities to impact heart disease in the clinical setting

Quality Improvement: Focus on NQI Measures

Quality Improvement: Focus on NQI Measures

- Approach:
  - Partnership with Louisiana Healthcare Quality Forum practice coaches
  - Provided technical assistance and on-site practice coaching to 14 health clinics, including several Rural Health Clinics and one Federally Qualified Health Center from 2016-2018

Quality Improvement: Focus on NQI Measures

- Intervention:
  - Utilized EHR to produce reports of National Quality Improvement measures for diabetes and hypertension control
  - Identified opportunities and updated processes to improve overall outcomes, utilizing a Plan-Do-Study-Act approach
    - Referral forms
    - Patient surveys
    - Policies
    - Standard Operating Procedures

Quality Improvement: Focus on NQI Measures

- Outcomes:
  - All sites were able to produce a report of NQI measures at conclusion of intervention
  - Three sites tracked additional process measures.

	A1c Up to date	Eye Exam annually	Lipid Panal annually	Microalbumin annually*	EKG annually
Pre	63%	9%	66%	9%	33%
Post	76%	19%	62%	36%	41%

Quality Improvement: Focus on NQI Measures

- Participating site feedback
  - Positive impact: “The action plan was effective, and following this led to an overall improvement in our target measures.”
  - Sustainability: “After completion, we have continued to utilize the processes that resulted from this project”
  - Competing priorities: Some clinics were unable to assign a dedicated staff member to this project.
  - Health IT: “We had some persistent difficulties with utilizing our EMR. We addressed with the EMR provider and anticipate future improvements”

Million Hearts: Hiding in Plain Sight

Million Hearts: Hiding in Plain Sight

- Approach:
  - Partnership with the Louisiana Public Health Institute
  - Implement the Hiding in Plain Sight protocol outlined by the Million Hearts initiative
  - Identify individuals with undiagnosed hypertension within a Federally Qualified Health Center

Million Hearts: Hiding in Plain Sight

- Intervention:
  - Staff at the FQHC conducted a manual chart review to identify patients with elevated blood pressure, regardless of the presence of a diagnosis
  - Reviewed over 500 charts

Million Hearts: Hiding in Plain Sight

- Outcomes:
  - Identified 100 patients with potentially undiagnosed hypertension

Total Identified	Description	Planned Follow-up	100
Diagnosis in chart	Diagnosis present in chart but missing from EHR	Added diagnosis to EHR	15
Untreated/Resolved	Pt had high BP at least once, but trend did not continue in hypertensive range	No current follow-up needed	19
Diagnosed at next visit	Pt had high BP at least once but was caught and diagnosed at subsequent visit	No current follow-up needed	9
Medicated but undiagnosed	Likely receiving HTN medication but diagnosed for comorbidity, i.e. diabetes	Flagged for PCP to review and see if diagnosis should be added	10
Undiagnosed/Untreated	**Potential hiding in plain sight cohort**	**Bring in for blood pressure screening, if high BP reading, triage for a PCP review for diagnosis and treatment**	47

Million Hearts: Hiding in Plain Sight

- Conclusions
  - Inability to use the EHR to pull the report made this a less sustainable initiative
  - FQHC made improvements to their patient visit workflow in order to ensure future patients met with a provider to receive a diagnosis
  - Staff reviewed proper documentation procedures to reduce the number of missing documented diagnoses

Conclusion

- Clinical sites were critical and invested partners, highly motivated to achieve improvements for their patients
- Well-Ahead learned key lessons related to our internal capacity to provide practice coaching, which we have enhanced under our new funding with the Population Health Cohort and Regional Practice Coaches
- The use of EHR is a critical component in making QI work efficient and sustainable and remains a challenge for many clinical sites
- Patient outcomes were improved by these interventions

Almost Lunch

Logistics – Preparing for Afternoon Workgroups

1	2	3
Provider Engagement in Hypertension Management Efforts	**Self-measured Blood Pressure Monitoring** Programs with Clinical Support	**Clinical - Community Partnerships** for Hypertension Management

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

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Really Really Close to Lunch

For the Low, Low Price of a Group Photo!

Million Hearts

Lunch

Resume at 12:45 pm

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Afternoon Breakouts / Facilitated Discussions

JOHN BARTKUS

Principal Program Manager
Pensivia

Million Hearts®

Breakout Workgroups

Topics based on the LA planning committee priorities…

1	2	3
Provider Engagement in Hypertension Management Efforts	**Self-measured Blood Pressure Monitoring** Programs with Clinical Support	**Clinical - Community Partnerships** for Hypertension Management

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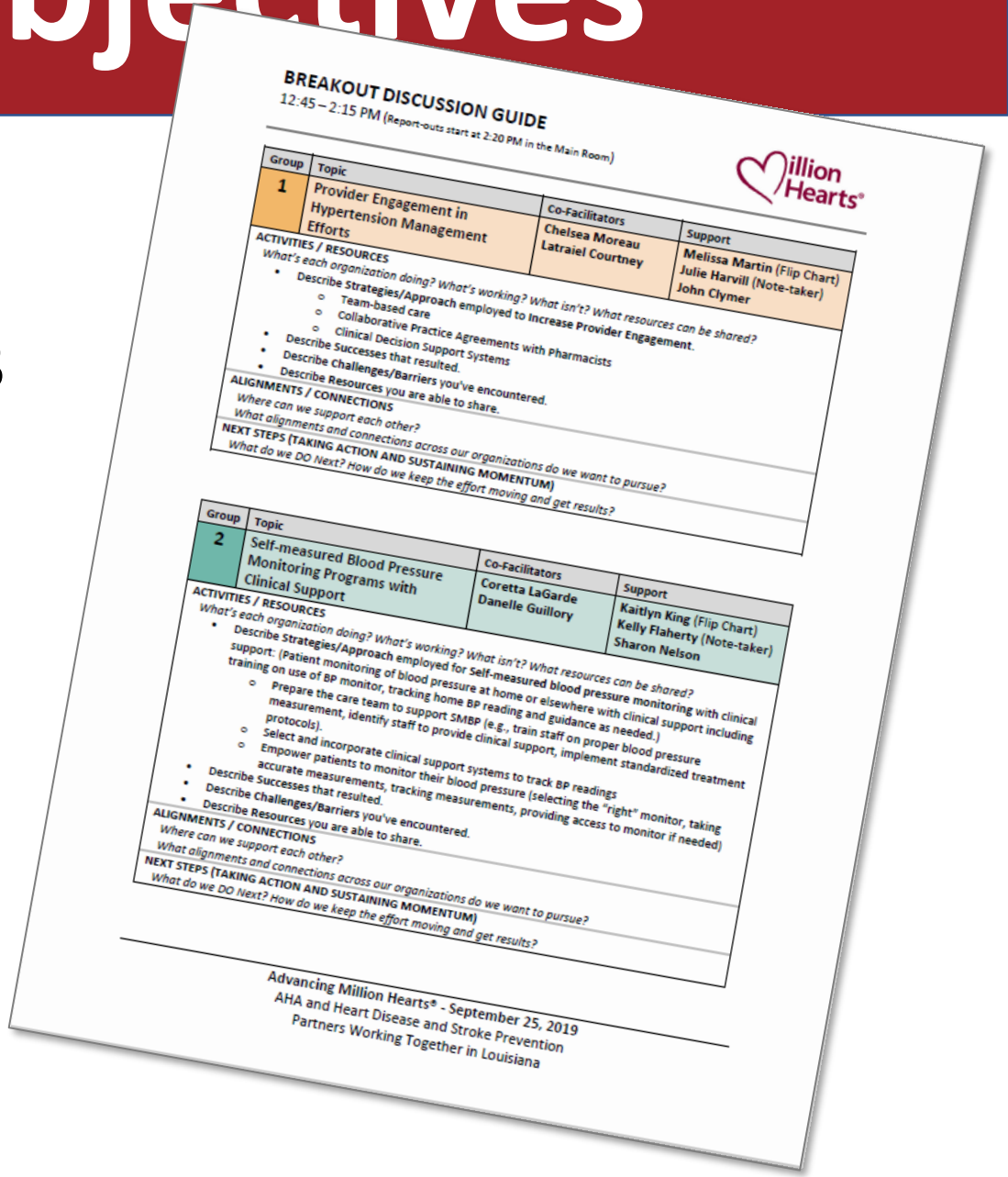
Workgroup Objectives

- Share **Activities / Resources**
- Identify **Alignments / Connections**
- Define **Next Steps / Sustainability**



BREAKOUT DISCUSSION GUIDE

12:45 – 2:15 PM (Report-outs start at 2:20 PM in the Main Room)

Group	Topic	Co-Facilitators	Support
1	Provider Engagement in Hypertension Management Efforts	Chelsea Moreau Latraiel Courtney	Melissa Martin (Flip Chart) Julie Harvill (Note-taker) John Clymer

ACTIVITIES / RESOURCES

What's each organization doing? What's working? What isn't? What resources can be shared?

- Describe **Strategies/Approach** employed to **Increase Provider Engagement.**
  - Team-based care
  - Collaborative Practice Agreements with Pharmacists
  - Clinical Decision Support Systems
- Describe **Successes** that resulted.
- Describe **Challenges/Barriers** you've encountered.
- Describe **Resources** you are able to share.

ALIGNMENTS / CONNECTIONS

Where can we support each other?

What alignments and connections across our organizations do we want to pursue?

NEXT STEPS (TAKING ACTION AND SUSTAINING MOMENTUM)

What do we DO Next? How do we keep the effort moving and get results?

Group	Topic	Co-Facilitators	Support
2	Self-measured Blood Pressure Monitoring Programs with Clinical Support	Coretta LaGarde Danelle Guillory	Kaitlyn King (Flip Chart) Kelly Flaherty (Note-taker) Sharon Nelson

ACTIVITIES / RESOURCES

What's each organization doing? What's working? What isn't? What resources can be shared?

- Describe **Strategies/Approach** employed for **Self-measured blood pressure monitoring with clinical support**: (Patient monitoring of blood pressure at home or elsewhere with clinical support including training on use of BP monitor, tracking home BP reading and guidance as needed.)
  - Prepare the care team to support SMBP (e.g., train staff on proper blood pressure measurement, identify staff to provide clinical support, implement standardized treatment protocols).
  - Select and incorporate clinical support systems to track BP readings
  - Empower patients to monitor their blood pressure (selecting the "right" monitor, taking accurate measurements, tracking measurements, providing access to monitor if needed)
- Describe **Successes** that resulted.
- Describe **Challenges/Barriers** you've encountered.
- Describe **Resources** you are able to share.

ALIGNMENTS / CONNECTIONS

Where can we support each other?

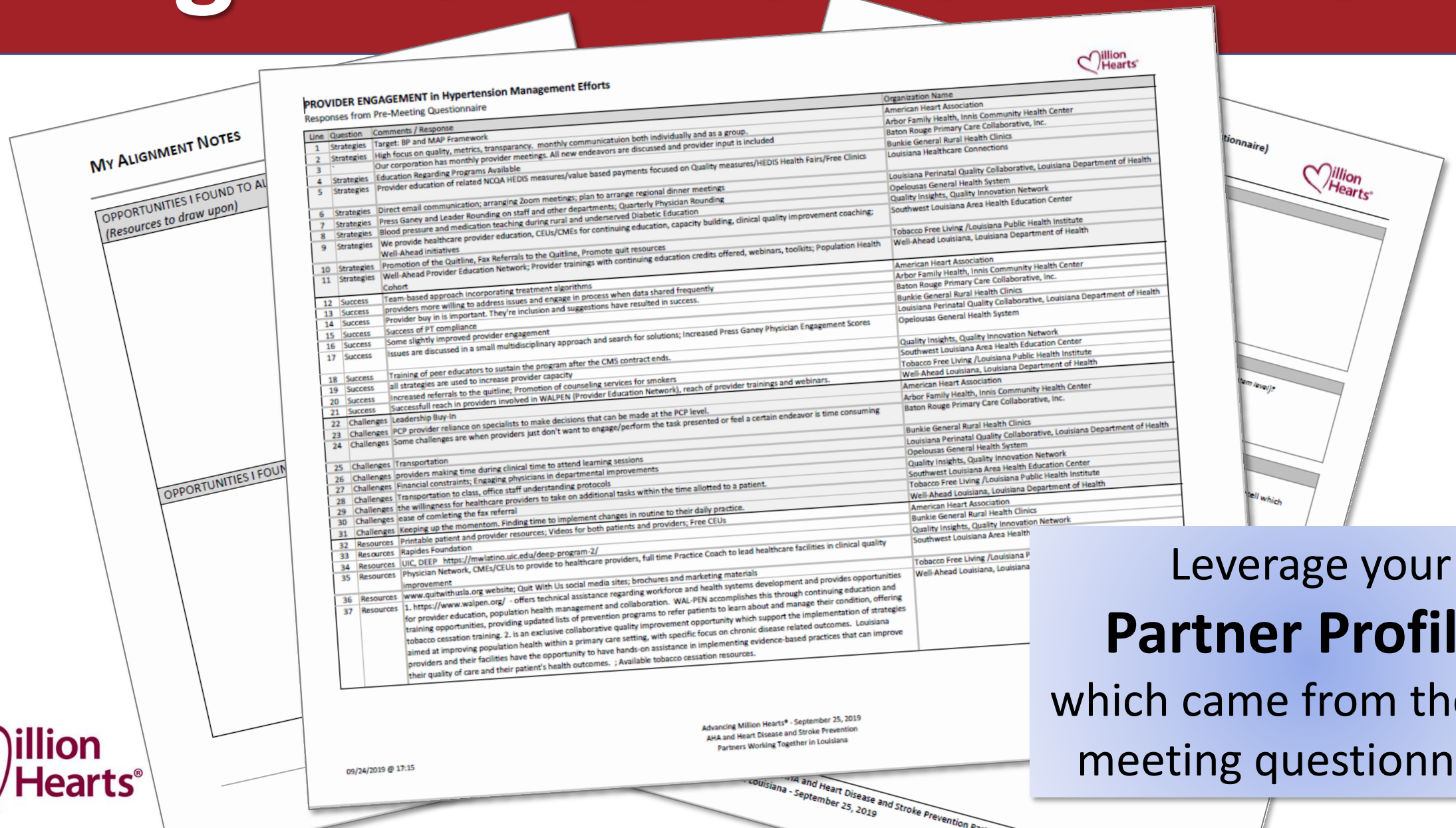
What alignments and connections across our organizations do we want to pursue?

NEXT STEPS (TAKING ACTION AND SUSTAINING MOMENTUM)

What do we DO Next? How do we keep the effort moving and get results?

Advancing Million Hearts® - September 25, 2019
AHA and Heart Disease and Stroke Prevention
Partners Working Together in Louisiana

Alignment and Connections



Leverage your

Partner Profiles

which came from the pre-meeting questionnaire.

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Breakout Workgroups

1 **Provider Engagement** in Hypertension Management Efforts	2 **Self-measured Blood Pressure Monitoring** Programs with Clinical Support	3 **Clinical - Community Partnerships** for Hypertension Management
Chelsea Moreau **Latraiel Courtney** Melissa Martin Julie Harvill John Clymer	**Coretta LaGarde** **Danelle Guillory** Kaitlyn King Kelly Flaherty Sharon Nelson	**Colleen Arceneaux** **Brian Burton** Ashley Hebert Erin Leonard Julia Schneider
Room (Here)	**Room**	**Room**

Group Report Outs

1 **Provider Engagement** in Hypertension Management Efforts	2 **Self-measured Blood Pressure Monitoring** Programs with Clinical Support	3 **Clinical - Community Partnerships** for Hypertension Management
Chelsea Moreau **Latraiel Courtney** Melissa Martin Julie Harvill John Clymer	**Coretta LaGarde** **Danelle Guillory** Kaitlyn King Kelly Flaherty Sharon Nelson	**Colleen Arceneaux** **Brian Burton** Ashley Hebert Erin Leonard Julia Schneider

* Notetakers – Please send your filled-in template to Julie Harvill or John Bartkus ! *

Evaluation and Feedback Process

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

Million Hearts®

Wrap Up / Adjourn

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