Advancing Million Hearts®

AHA and Heart Disease and Stroke Prevention

Partners Working Together in Utah

June 06, 2019

Meeting Summary

Library's Viridian Event Center
8030 South 1825 West
West Jordan, Utah

Meeting Purpose:

The purpose of the meeting is to connect staff from the American Heart Association affiliate, 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:

- Identify Million Hearts® focused activities for 2019
- Recognize Million Hearts® evidence-based and practice-based CVD prevention strategies and approaches
- List partner programs and resources that align with Million Hearts®
- Identify programs efforts that align and ways to work together
- Create a plan for follow-up to increase engagement
- Recognize key contacts within heart disease and stroke prevention

Million Hearts® 2022:

- Keeping people healthy
- Optimizing care
- Improving outcomes for priority populations

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®.

Key Themes:

- Add to and utilize the strengths of the Utah Million Hearts Coalition to carry out and sustain the work.
- Market AOBP and educate providers on the proper use of AOBP in conjunction with SMBP
- Identify role of team members in providing quality care for patients

AGENDA

Time	Agenda Item/Topic	Speaker/Facilitator
8:30 – 9:00 am	**Partner Networking**	
9:00 – 9:15 am	**Welcome** **Overview of the Day**	**John Clymer** Executive Director, National Forum for Heart Disease and Stroke Prevention **Julie Harvill**
9:15 – 9:30 am	**Utah Million Hearts Coalition Overview**	**Edwin Espinel** Healthy Living through Environment, Policy, and Improved Clinical Care, Utah Department of Health
9:30 – 9:50 am	**Introductions** In one sentence, what excites you about your role in heart disease and stroke prevention?	**John Bartkus, PMP, CPF** Principal Program Manager, Pensivia
9:50 – 10:10 am	**Million Hearts® 2022** • Million Hearts® Accomplishments • What must happen to prevent? • 2018 Focus **Q and A - Group Interaction**	**Tom Keane, JD, MPA** Acting Policy and Partnerships Lead, Division for Heart Disease and Stroke Prevention, Centers for Disease Control and Prevention
10:10 – 10:30 am	**Utah Department of Health Priorities that Align with Million Hearts**	**John Stuligross, MPH** Cardiovascular and Health Systems Coordinator, Utah Department of Health
10:30 – 10:45 am	**Break**	
10:45 – 11:05 am	**Comagine Health Priorities that Align with Million Hearts**	**Katherine Luke** Project Manager, Utah Outpatient Services, Comagine Health **Rebecca Wilson** Senior Project Manager, Comagine Health
11:05 – 11:25am	**American Heart Association/American Stroke Association programs and resources that align with Million Hearts**	**Marc Watterson** Director of Government Relations **Juliette Martinez** Community Impact Consultant **Jessica Rosing** Regional Director, Quality and Systems Improvement
11:25 – 11:45 am	**Finding Connections and Alignments**	**John Bartkus**
11:45 – 12:15 pm	**Lunch**	
12:15 – 2:20 pm	**Afternoon Breakouts/Facilitated Discussions** • Blood Pressure Monitoring (AOBP, SMBP) • Team-Based Care • Treatment Protocols	**John Bartkus**
2:20 – 2:50 pm	**Group Report Outs and Next Steps** • What are you planning to do? • How will you get it done? • What are the next steps?	**John Bartkus**
2:50 – 3:00 pm	**Evaluation and Feedback Process**	**Sharon Nelson, MPH** Program Initiatives Manager, Million Hearts Collaboration, American Heart Association
3:00 pm	**Adjourn**	

Introductions

What excites you about your work in heart disease and stroke prevention?

- Keeping families together longer
- Keeping our health plan members healthy
- Educate members in their home about prevention
- Linking community members to services
- Work with clinics and help patients to be healthier
- Hear about the innovations that clinics and providers are engaged in
- Seeing all the different settings that are working on this issue
- The work I do every day impacts people's real lives
- Impact for future generations
- We know the answers and can accomplish the goals
- I like to move scientific advances to the clinic
- Connector between the plan and the patients
- How can we make state and local connections to create opportunities for health for all
- Work with medical team in our clinics to educate patients to live longer, higher-quality lives
- Being part of an organization that can provide tools to help people who are on the ground doing the work
- Bring people together to focus on issues related to women's heart health
- Opportunity to be part of collective effort to address key PH issue
- We are able to move the needle when we work together
- Help get BP monitors to people so they can measure in the home
- Work with our physicians to make our communities healthier
- Bringing awareness to our rural communities and bridging connections
- Ability to create healthy workplace environments and connect them to health services
- Seeing cultural shifts within communities that help people live healthier lives
- Getting to work every day with people who are passionate about making important, positive changes
- Working with women to help prevent stroke and heart disease
- Excited to learn more about how to increase efforts to address tobacco use
- Come up with equitable solutions that will best serve the community
- Seeing the education sink in with patients
- Making connections throughout the community to support quality living
- Helping frontline staff do their best work
- Work with clinics on team-based care
- Work with clinicians and providers to improve care
- Work directly with frontline staff and providers to improve care
- Work with FQHCs to help prevent and manage disease
- Elevate the voice of under-resourced communities; equip our providers with educational resources; partner with clinics to see attainable outcomes

Breakout Groups

Group	Topic	Leader	Co-Leader	Notetakers
1	Blood Pressure Monitoring (AOBP/SMBP)	Katherine Luke	Miriam Patanian	Linnea Fletcher Sharon Nelson
2	Team-based Care	John Stuligross	Juliette Martinez	Tom Keane Katie Scholes
3	Treatment Protocols	Edwin Espinel	John Clymer	Maralie Nordfelt Julie Harvill

BREAKOUT GROUP 1: BLOOD PRESSURE MONITORING (AOBP/SMBP)

Participants:	Nathan Patterson	Shelia Sarten	SaRene Brooks	Brittney Okada
Marc Watterson	Karlie Kola	Shelly Jo Ness	Bethsabe Beccera	Rebecca Wilson
Barry Stultz	Alysia Ducuara	Sarah Bagley	Mallory Spendlove	

Discussion Leads:	*Flip Chart Notes:*	*Notetaker:*
Katherine Luke	Linnea Fletcher	Sharon Nelson
Miriam Patanian		

BACKGROUND

Routine clinic BP checks are done incorrectly 95% of the time.
Accurate BP measurements are critical to diagnosing and treating hypertension.
8-11 minutes is needed to obtain a Guideline-quality measurement.
Patients may experience "White Coat Syndrome", which causes high/elevated blood pressure readings

- Self-Measured Blood Pressure Monitoring (SMBP), can alleviate some of the effects of "White Coat Syndrome". Patients monitor their BP on their own and keep track of their BP readings. However, it can be time consuming and costly to implement an SMBP program.
- Automated Office Blood Pressure Monitoring (AOBP) is another strategy for decreasing impact of "White Coat Syndrome" and the need for SMBP. AOBP takes three readings and an average while the patient is alone in the room.
    - Take the BP in the clinic and if the reading is high, then an AOBP monitor should be used to see if the reading is correlated to the high blood pressure reading to the "white coat". If the reading is still high, then the patient will do the SMBP reading.

ACTIVITIES / RESOURCES / ALIGNMENTS / CONNECTIONS

What is each organization doing? What resources do they bring? Where can we support each other? What alignments and connections across our organizations do we want to pursue? (How can we cultivate and leverage these alignments / connections?)

WHAT is each organization doing?

Southeast HD – lack of training and knowledge of the staff. Don't know what has done in the past. Physicians think that it is difficult to implement the program. Provided pamphlets.

Central HD – bringing added value with the award. Some clinics are overwhelmed

Passion for the work
Have built good relationship with clinics

Intermountain Healthcare (IHC) can support some of the clinics with the AOBP monitors. IHC support areas with a hospital.
Help clinics adapt to utilization of the AOBPs
Success stories of implementing and using AOBP – healthcare provider champion is helpful.
Make sure that the AOBP is working and accurately calibrated.

Would health plans be willing to cover the costs of the AOBP if this is the gold standard of measurement?
Payers are providing the SMBP but unaware of covering the AOBP.
How can we incentivize the health plans to cover the machines? This is a good question for the Health Plan Partnership.
HealthInsight.org/bloodpressure – clinician to clinician. AOBP will improve the clinics overall hypertension control rate.
Resources and discounts for the BP monitors

Next steps: How do you actually implement AOBP in clinics?

- List of common stumbling blocks to reporting measures
- Protocol and procedures for the workflow
- How to "market" AOBP

OBJECTIVES (STUFF WE AGREE TO GET DONE TOGETHER)

What are the Primary Outcomes this workgroup seeks to accomplish?
(Results; The end; The whole; Large in size – the ultimate accomplishments of the workgroup)

1. Develop a plan to market AOBP and educate providers on its value – there needs to be buy-in, how to implement and business process
2. Provide success stories and helping a larger group of providers and clinics to implement the AOBP
3. Build the case for health plans to cover AOBPs

HOW do we accomplish this? What specific actions or tasks need to be carried out in order to complete each step?

Barriers: getting good education to the clinics, and marketing the program for change; cost for purchasing the AOBPs and SMBPs

How will you provide deeper implementation of clinic protocol to have AOBP?

WORKPLAN

- **DELIVERABLES**
  What specific Deliverables (tangible outcomes or services) need to be completed in order to achieve our agreed objectives? When should this be completed? (Deliverables are Nouns. Products/Services/Outcomes)
- **SUPPORTING ACTIONS / TASKS (WHO COMMITS TO DOING WHAT?)**
  What are the Actions to be taken to achieve the Deliverable? When do they need to be done?

DELIVERABLE	**Education and Marketing**		
ACTIONS	**Action / Task**	**Owner**	**By Date**
	• Education: Familiarize current staff and coalition members with what resources are available • Understand the gaps from Million Hearts Applications • Identify categories of interest	Comagine and LHDs	01Oct2019
	• Marketing: Create a business case/Literature Review	Mallory / MH Coalition, Katherine and Edwin	

DELIVERABLE	**Incentivize plans to provide AOBP**		
ACTIONS	**Action / Task**	**Owner**	**By Date**
	• Provide information to the Health Plan Partnership – provide something similar to the business case	Katherine and Verana	Aug2019

DELIVERABLE	**Develop deeper implementation protocols**		
ACTIONS	**Action / Task**	**Owner**	**By Date**
	• Review survey results given to clinics	Dr Stultz / EPICC	Nov2019
	• Develop a toolkit for deeper implementation guide and protocol		

BREAKOUT GROUP 2: TEAM-BASED CARE

Participants:	Kristen Brimley	Zach Miller	Ashley Rush	Sunny Hayes
Linda Johnson	Estefania Mondragon	Leanne Johnston	Annie Mervis	
Jennifer Puder	Kaylynn Lucas	Frances Serrano	Anna Testa	

Discussion Leads:	*Flip Chart Notes:*	*Notetaker:*
John Stuligross	Katie Scholes	Tom Keane
Juliette Martinez		

BACKGROUND

Team-based care begins with front office staff and continues through the appointment to the CHW and the pharmacist to connect back to the primary care provider office. Making sure all key functions are being involved.

ACTIVITIES / RESOURCES / ALIGNMENTS / CONNECTIONS

What is each organization doing? What resources do they bring? Where can we support each other? What alignments and connections across our organizations do we want to pursue? (How can we cultivate and leverage these alignments / connections?)

UDOH is fully utilizing pharmacists and dieticians.
Better define team-based care
Utilizing social work, care plans, patient engagement for treatment plan to choose lifestyle changes, patient education, utilizing pharmacy and CHW pilots
Take pt approach NOT condition approach
Front desk to MA to physician/RN.
Determine social health (environment, financial, support), where does the patient fall?
Have a BP monitor in the waiting room to practice SMB before the visit and compare with the MA/AOBP result
Utilization of call centers, scheduling, nutritionist, case management
Look at closing the referral loop
Involve all the players in the morning huddle
High-risk patients are discussed at care conference monthly
Learn how to utilize the manpower you have accessible to you
Utilize telehealth
Utilize therapists for team-based trauma-informed care
Use MAs to perform ACE study
Bridging gaps between the health plan; those who don't quality

Resources to provide service
How to pay for team members
How to implement team-based care
Knowledge, ability to pay, embedded vs centralized model
How to identify patients
What can be billed
Training on billing for services
Understanding reimbursement, ROI
Closing referral loops
Job descriptions

1) Bridging gap between providers
2) How to implement team-based care
3) Closing gaps

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?

How do you currently use your resources? How can you greater utilize them?
Is this something clinics want to do?
Find your champions
Assess ourselves, our clinics, our patients
Looking at behavior after diagnosis
Look at my cardiac coach app
Create an action plan

1. Perform clinic needs assessment
2. Behavior assessment pt

A workgroup could be formed to carry out:

1. Gauge interest
2. Assessment
3. Action plan

SUSTAINABILITY
Who can commit to a workgroup? See list from John S. This model has been implemented in CA, AZ, VT, and others. Ashley and Linda are the co-chairs

WORKPLAN

- **DELIVERABLES**
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- **SUPPORTING ACTIONS / TASKS (WHO COMMITS TO DOING WHAT?)**
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DELIVERABLE	**Bridging the gap between payers and providers**		
ACTIONS	**Action / Task**	**Owner**	**By Date**
	• Determine resources available	Subcommittee	
	• Reimbursement mechanisms roadmap	Subcommittee	
DELIVERABLE	**How to implement team-based care**		
ACTIONS	**Action / Task**	**Owner**	**By Date**
	• Identify roles of team members and who can assist other members	Subcommittee	
	• Bring team-based care to rural and underserved communities	Subcommittee	
	• Clinical-based assessment implementation support	Subcommittee	
	• How to scale team-based care to meet the patient where they are	Subcommittee	
	• How to use train-the-trainer model to close the referral loop	Subcommittee	

BREAKOUT GROUP 3: TREATMENT PROTOCOLS

Participants:	Jessica Rosing	Chanda Sundara
Kristin Hunter	Julie Christie	
Violet Brown	Hannah Payne	

Discussion Leads:	*Flip Chart Notes:*	*Notetaker:*
Edwin Espinel	Maralie Nordfelt	Julie Harvill
John Clymer		

ACTIVITIES / RESOURCES / ALIGNMENTS / CONNECTIONS

What is each organization doing? What resources do they bring? Where can we support each other? What alignments and connections across our organizations do we want to pursue? (How can we cultivate and leverage these alignments / connections?)

What is each organization doing?

UofUHealth:

- Registry of HTN patients
  - Patients are automatically included after 6 high BP readings, regardless of diagnosis status
  - Track follow-up care
- Group HTN education classes
  - Offered weekly
  - Led by clinicians
  - Question: Does provider receive feedback about attendance/progress?
- Nurse-led HTN clinic
  - Patient visits every 2 weeks
  - Adjust Rx with provider, as necessary
- Team-based care for highest risk patients

AHA:

- "Guidelines on the Go"
  - Online quick guide for providers
  - How to treat patients (algorithm)
- Patient education
  - Infographics
  - Interactive workbook
  - App

Utah Million Hearts Coalition:

- AOBP/SMBP webinar (Dr. Barry Stultz)
  - CME credits for physicians
  - Available on coalition website

Molina:

- Share all patient education materials with providers
  - Everyone is on the same page
- Outreach to members to get them into care
  - By mail, phone- any means necessary!

LHDs:

- Encourage clinicians to utilize recommended protocols
- Provide assistance creating registries to ID undiagnosed and/or patients not adhering to treatment

Comagine:

- Has Patient Advisory Council that MH can access for feedback and perspectives

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What resources do you bring for this topic?
Where can we support each other?
What alignments and connections across our organizations do we want to pursue?
OTHER DISCUSSION NOTES/THOUGHTS:

Define "treatment protocols"

- How patients receive care
- "If you have A, then do B"
- Standard of care
- Best practices
- How to treat a patient

Health plans focus on preventive/in-office (not hospital)

What do we do with pre-HTN patients (before diagnosis)?

- Patient education
  - What HTN actually does to your body; how it affects your life
  - Accurate measurement

How do we get best practice standards/info to providers?

Let providers decide on their own diagnosis standards

- Uniform by practice location?
- Not everyone is on board with new ACC guidelines

Doctor-patient relationships are key in treatment

- Partnerships, not just relationships
- Must consider patient circumstances, behavior, education, etc.
- Balance with treatment algorithms

Can/will coalition endorse a specific treatment guideline?

- Does it need to?
- UDOH technically separate from coalition

OTHER THOUGHTS FROM LARGE GROUP:

- When proscribing treatment, give patients *options* to try
- Invite RDs to the table

OBJECTIVES (STUFF WE AGREE TO GET DONE TOGETHER)
What are the Primary Outcomes this workgroup seeks to accomplish?
(Results; The end; The whole; Large in size – the ultimate accomplishments of the workgroup)

Identify HTN patients who are not adhering to treatment
- Create registries?
- Wait-- More input is needed to see if…
    - There is a need for this
    - It's an appropriate activity for the coalition (LHD role?)
    - It's feasible

Uniform education materials (about medication/treatment) for providers/patients across health systems
- Coalition already provides this on website

More provider representation on coalition
- Invite:
    - Drs, Systems, Plans, Community groups?
    - Other providers: Pharms, RDs
    - Patients!

New coalition workgroup focusing on clinical protocols
- Utilize clinician representation on coalition

Have a "comment period" section on website
- To gather more input from others who can't participate on coalition

What other materials need to be added to coalition website?

Split resources & Education coalition workgroups back into two?

HOW do we accomplish this?
What specific actions or tasks need to be carried out in order to complete each step?
- Form Treatment Protocol ad hoc group Vol – Jessica at AHA
- identify Non-adherent patients
    - Registry
    - Gather more input on whether this is need and where
    - best Practices

- Standardized education materials
    - What materials need to be added to million hearts webpage
    - Divide resource and education workgroup

- Million Hearts Coalition endorse Guidelines – need to identify if this is possible

- Treatment protocols – Define
    - How patients receive care
    - evidenced base guidelines/best practices/standard of care

- Hypertension
    - Molina: 1849, 140/90 is adequate
    - Patient education - what is hypertension? What are its life consequences? How to prevent?

- Accurate Measurement essential
- Registry (6 high reading over two years)
- Protocols for Screening and TREATMENT
- aha guidelines on the go
    - Normal - < 120/80

- Resources to support protocols –
    - AHA has many guides, info sheets, workbooks, etc. for patients.
    - Peer groups online

Some providers have decided to adopt new guidelines, AHA, ACC and some have not
Treatment plans tailored to individual patients
Provider-patient relationship is key
Nurse led hypertension clinic for patients in grey area

Molina: Educate providers and patients on same topics
use multiple communication channels to reach patients who are not seeing providers
UofU has resources to strengthen provider patient relationship
Are there protocols for finding undiagnosed hypertension?

- IDENTIFY NON-HYPERTENSIVE PATIENTS WHO ARE NON-ADHERENT TO TREATMENT

EDUCATION FOR PROVIDERS
EDUCATION FOR PATIENTS
=
SO, PATIENTS DON'T GET DIFFERENT INFORMATION FROM DIFFERENT PROVIDERS

CLINICAL PROTOCOL WORKGROUP WITH ALL RELEVANT GROUPS:

1. Patients
2. Providers
3. Plans
4. Systems
5. Employers

WORKPLAN

- **DELIVERABLES**
  What specific Deliverables (tangible outcomes or services) need to be completed in order to achieve our agreed objectives? When should this be completed? (Deliverables are Nouns. Products/Services/Outcomes)
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DELIVERABLE	**MORE CLINICIAN REPRESENTATION ON UTAH MILLION HEARTS COALITION (E.G. DOCTORS, HEALTH PLANS, PHARMACISTS, DIETICIANS, PATIENTS)**		
ACTIONS	**Action / Task**	**Owner**	**By Date**
	• Split current workgroups, have "education" focus on this topic; additional actions on pages 10-11.	UT Million Hearts Coalition	
	• Jessica Rosing (AHA) will be part of workgroup	Jessica Rosing	

Pre-Meeting Survey and Results Summary:

This survey was used to finalize the meeting agenda and presentations, and to provide the most valuable information for those working in heart disease and stroke prevention.

1. Organization Name:
2. Name:
3. What is your primary role/function within your organization?
4. Is your organization currently a member of the Utah Million Hearts Coalition?
5. Is your organization interested in participating in the Million Hearts Coalition?
6. Which of the following Million Hearts 2022 goals is your organization addressing in 2019? Answers are ordered as survey respondents ranked them.
    a. Decreasing tobacco use
    b. Engaging patients in healthy behaviors
    c. Controlling blood pressure
    d. Increasing physical activity
    e. Reducing sodium intake
    f. Managing cholesterol
    g. Promoting aspirin use when appropriate
    h. Increasing use of cardiac rehabilitation
7. Topics ranked in order of priority based on the survey.
    a. Team-based care
    b. Implementation of recommended hypertension and hypercholesterolemia treatment protocols
    c. Self-measured blood pressure monitoring
    d. Automated office blood pressure monitoring
    e. Medication adherence
    f. Cardiac rehabilitation

8. What do you envision as the 3 most critical actions for the Utah Million Hearts Coalition in advancing hypertension control in the state? Responses include:
    - SMBP training for providers and community
    - Address social determinants of health
    - Deep dive into cholesterol and adoption of ASCVD risk calculator
    - More upstream and outpatient interventions
    - Streamlining resources with all partners
    - Access to care
    - Automated office blood pressure monitoring (AOBP)
    - SMBP
    - Team-based care
    - Identifying clinic and provider gaps
    - Pushing providers to more excellent processes
    - Aligning priorities
    - Blood pressure management protocols in the clinic
    - Ensure proper technology and equipment are available to clinical partners, such as AOBP machines
    - Clinician training
    - Preventive care
    - Education and awareness taught in the community
    - AOBP
    - Team effort with primary care providers educating patients in their office at appointments
    - Working relationships between the health plans and providers
    - Team effort with county health programs
    - Engagement of new partners: patients, OB-GYNs, pediatricians, dentists, etc.
    - Advancing AOBP
    - Decreasing tobacco use – encourage team-based care and new partners with similar goals
    - Focus on best practices to achieve good hypertension control rates
    - Ensure LHD contract objectives align with the Million Hearts Award criteria
    - Healthy behavior education including nutrition and clarifying contradictory information

- Address sex and gender differences in prevention, diagnosis, and treatment of CVD
- Increasing physical activity to help reduce chronic conditions
- Decreasing tobacco use
- Managing cholesterol
- Unified approach – working towards the same goal(s)
- More engagement within the coalition; increased organizationally diverse membership
- Providing support to small independent clinics
- Create a strategic plan that incorporates all coalition members
- Promotion of the use of health IT, evidence-based processes, and adoption of healthier behaviors
- Increase outreach to clinics and providers outside of the DQHC setting, such as OB/GYN, orthopedics, dentistry
- Expand reach by increasing membership of coalition
- Promotion of systemic policies to improve early diagnosis of people with hypertension
- Teach citizens the correct methods of blood pressure measurement to empower them to have correct measurements taken
- Streamlining activities with other statewide efforts around similar chronic conditions
- Bring awareness to cardiovascular health disparities among priority populations
- Promote primary prevention efforts in youth

Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners
Working Together in Utah - Partner Profile Summary
Compiled from Pre-Meeting Questionnaire for the 06Jun2019 In-Person Meeting

Million Hearts® Goal Focus and Organizational Priorities

	Million Hearts® Partner Organization	MH GOAL FOCUS: Decreasing tobacco use	Engaging patients in healthy behaviors	Controlling blood pressure	Increasing physical activity	Reducing sodium intake	Managing cholesterol	Promoting aspirin use when appropriate	Increasing use of cardiac rehabilitation
1	American Heart Association	✓	✓	✓	✓	✓	✓	✓	✓
2	Association for Utah Community Health								
3	Bear River Health Department	✓		✓	✓	✓			
4	Central Utah Public Health	✓	✓	✓	✓	✓			
5	Comagine Health	✓	✓						
6	Division for Heart Disease and Stroke Prevention (CDC)	✓	✓	✓	✓	✓	✓	✓	✓
7	Intermountain Healthcare		✓	✓					
8	Molina Healthcare of Utah	✓	✓		✓				✓
9	Salt Lake County Health Department (SLCoHD)	✓	✓	✓	✓	✓	✓		
10	Southeast Utah Public Health Department (SEUHD)	✓	✓	✓	✓				
11	Southwest Utah Public Health Department		✓	✓			✓		
12	Tooele County Health	✓		✓	✓				
13	TriCounty Health Department	✓	✓	✓	✓	✓	✓	✓	✓
14	University of Utah Health		✓						
15	University of Utah Health Plans	✓	✓						
16	Utah County Health Department	✓	✓	✓	✓	✓	✓		
17	Utah Department of Health	✓	✓	✓	✓		✓	✓	
18	Utah Partners for Health	✓		✓				✓	
	Count of Organizations	14	14	13	11	7	7	5	4
	% of Organizations	78%	78%	72%	61%	39%	39%	28%	22%

17 Organizations responded

	ORGANIZATIONAL PRIORITIES (Ranked): Team-based care	Implement of hypertension treatment protocols	Self-measured blood pressure monitoring	Automated office blood pressure monitoring	Medication Adherence	Cardiac Rehabilitation
AHA	6	1	5	2	4	3
AUCH	1	2	4	3	6	5
BRHD			1	2		
CUPHD	2		1			
Comagine	1	3	2	4		
CDC	4	2	1	6	5	3
IH	1	2		4	3	
Molina	1	2	4	5	3	6
SLCoHD	4	1	3	2	5	
SEUHD						
SWUHealth		2	3	1		
TooleHealth						
TCHD	1	4	3	2	5	6
UoUH	1					
UoUHP						
UCHD			2	1		
UDOH	2	4	1	3		
UPFH	1	3		2		
Avg	2.1	2.4	2.5	2.8	4.4	4.6

Average Ranking (1 is highest rank)

15 Organizations responded

Presentations:

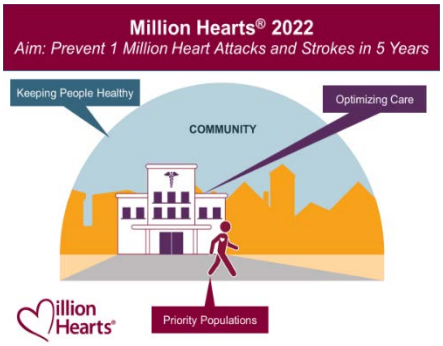
Overview

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

This day is about bringing together multiple sectors to improve collaboration to get our population to a desired state of health. As laid out in *The American Health Care Paradox: Why Spending More is Getting us Less*, by Elizabeth Bradley and Lauren Taylor, the US spends $0.55 on social services for every $1 spent on health care. In every other OECD country, for every $1 spent on health care, $2 is spent on social services. We need community-based services as much as we need an effective health care system.

Million Hearts® 2022

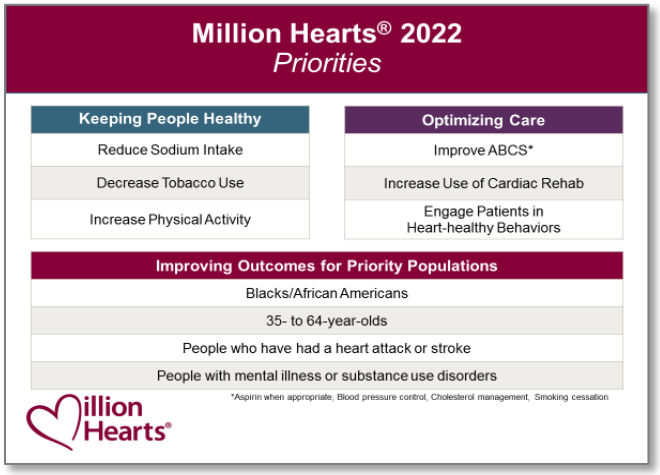
Tom Keane, JD, MPA
Acting Policy & Partnerships Team Lead
Division for Heart Disease and Stroke Prevention, CDC



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.

Million Hearts is developing a recognition program for hospitals and health systems that will recognize clinical institutions working systematically to improve the cardiovascular health of the population and communities they serve by 1) keeping people healthy, 2) optimizing care, 3) improving outcomes for priority populations, or 4) innovating for health. Systems that apply will need to address a minimum of one strategy in at least three of the four priority areas. This program will be launched later in 2019.



Utah Department of Health Addresses Priorities that Align with Million Hearts®

Edwin Espinel
Healthy Living Through Environment, Policy, and Improved Clinical Care
Utah Department of Health

Utah Million Hearts Coalition
The mission of the coalition is to prevent heart attacks and strokes in Utah through improved clinical care and accurate blood pressure measurement and control in health care settings and at home.

- 2 Workgroups
  - Million Hearts Awards - recognize outstanding Champion Clinics in Blood Pressure Management and Hypertension Control
    - Began in 2016 with 13 applications
    - Increase in applications every year to 133 in 2019
    - Everyone who applies receives a $500 stipend, shares a snapshot of their hypertension control data with the Department of Health
  - Education/Resources
    - Resources developed for clinic staff in English and Spanish

John Stuligross
Cardiovascular and Health Systems Coordinator
Utah Department of Health

The Utah Department of Health has three strategic priority areas:
- Healthiest People
- Optimize Medicaid
- A Great Organization

Environment, Policy, and Improved Clinical Care (EPICC) Unit
- Clinical Interventions
  - Working with EHRs – how to leverage EHRs to monitor hypertension, diabetes, etc.
  - Blood Pressure Monitors – AOBP / SMBP. How can we get better diagnoses and how do we get people to better manage their hypertension?
  - Medication Adherence –
  - Team-Based Care – how do we define team-based care? How do we promote that throughout the state?
  - Telehealth – how to use technology to improve access to care
- EPICC carries out this work through multiple groups
  - Local health departments
  - Registered dietician pilots
  - Pharmacy work and research
  - Health Plan Partnership
  - Million Hearts Coalition

Comagine Health Priorities and Alignment with Million Hearts®

Katherine Luke
Project Manager, Utah Outpatient Services
Comagine Health

Rebecca Wilson
Senior Project Manager
Comagine Health

- ✓ **Engage providers**: To improve patient care with evidence-based best practices
- ✓ **Encourage collaboration**: Among providers and other community stakeholders
- ✓ **Empower patients**: To take an active role in managing their health

Align with the Million Hearts® Initiative to improve preventive care measures, including aspirin use, blood pressure control, cholesterol management and smoking/tobacco education. Target disparate populations, including gender, racial and ethnic disparities and rural populations, to improve cardiac health

- Improve behavioral health
- Increase patient safety
- Increase chronic disease self-management (cardiac and vascular health, diabetes)
- Increase quality of care transitions

What are your top cardiac priorities? Each organization in attendance provided a response to this.

- University of Utah – Primary outpatient priority: effective, accurate blood pressure measurement using AOBP, ambulatory 24-hour monitoring, SMBP
- WISEWOMAN – reduction of hypertension, reduction in CVD
- Intermountain Healthcare – hypertension control, new hypertension workgroup in development
- Association for Utah Community Health (AUCH) – Helping identify pts within CHCs with undiagnosed hypertension
- University of Utah Health Plan – work with network providers to help to identify gaps in care
- Molina – more people enrolled in a health plan with a free gym membership, no-cost blood pressure monitor, work with pharmacy team to identify patients that are falling out of medication adherence, those with diabetes that aren't on a statin

American Heart Association/American Stroke Association Programs and Resources that Align with Million Hearts

Marc Watterson
Director of Government Relations,
Utah American Heart Association

Juliette Martinez
Affiliate Community Impact Consultant, Western States Affiliate, American Heart Association

Jessica Rosing
Regional Director, Quality and Systems Improvement
American Heart Association

Policy Priorities:

- ✓ Safe Routes to School (Harrison)
- ✓ Tobacco Prevention and Cessation Funding (Ray)
- ✓ Healthy Food Incentive Program Funding (Handy and Davis)
- ✓ Tobacco to 21 (Eliason)

Programs to improve health

- Check.Change.*Control.* program and Target: BP – designed to eliminate high blood pressure among Americans. More than 500,000 people have participated.
- Check.Change.*Control.*Cholesterol – modeled after the original program that focused on hypertension control, this program targets Americans with high cholesterol.
- Heart-Check Mark – makes it easier to spot healthier choices in the grocery store or when dining out. There are more than 900 products that carry the mark.

Contact List

FirstName	LastName	Organization	Title
Alysia	Ducuara	Salt Lake County Health Department (SLCoHD)	Program Coordinator
Anna	Testa	State of Utah	Registered Nurse
Annette	Prall	Weber-Morgan Health Department	(blank)
Annie	Mervis	University of Utah Health	Director, Quality Improvement & Population Health
Ashley	Rush	Healthy Living Through Environment, Policy & Improved Clinical Care (EPICC)	Team Based Care Specialist
Barry	Stults	University of Utah Health	Internal Medicine Physician
Bethsabe	Becerra	Weber-Morgan	Community Health Educator
Brittney	Okada	Utah Department of Health Office of Health Disparities	Health Equity Specialist
Chanda	Sundara	University of Utah Health	Quality Improvement Specialist
Darrell	Garcia	Steward Health Care Network	Performance Liaison
Dustin	Jones	Utah Department of Health	Worksite Coordinator
Edwin	Espinel	Utah Department of Health	Health Systems Specialist
Frances	Serrano	University of Utah Health Plans	Accreditation Specialist
Hannah	Payne	University of Utah Health	Quality Improvement Specialist
Jennifer	Puder	Salt Lake County Health Department (SLCoHD)	Registered Nurse
Jessica	Rosing	American Heart Association	Regional Director, Quality and Systems Improvement
John	Bartkus	Pensivia	Principal Program Manager
John	Clymer	National Forum for Heart Disease & Stroke Prevention	Executive Director
John	Stuligross	Utah Department of Health	Cardiovascular and Health Systems Coordinator
Joyce	Kim	Steward Health Network	Community Relations Manager
Julie	Christie	Utah Department of Health	Health Program Specialist
Julie	Harvill	American Heart Association	Operations Manager
Juliette	Martinez	American Heart Association	Community Impact Director - Affiliate Health Strategies
Karlie	Kola	Bear River Health Department	Health Educator
Katherine	Luke	Comagine Health	Project Manager
Katie	Scholes	TriCounty Health Department	Health Educator
Kaylynn	Lucas	Utah Partners For Health	Quality Director
Kristen	Brimley	Davis County Health Department	Health Educator
Kristin	Hunter	Molina Healthcare of Utah	Sr. Quality Specialist, Interventions
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Mary Jo	Garofoli	National Forum for Heart Disease & Stroke Prevention	Operations Analyst
Miriam	Patanian	National Association of Chronic Disease Directors	Lead Consultant for CVH & Health Systems
Nathan	Peterson	Intermountain Healthcare	Community Health Manager
Rebecca	Wilson	Comagine Health	Senior Project Manager
Sarah	Bagley	Central Utah Public Health	Health Educator
SaRene	Brooks	Summit County Health Department	Health Educator
Sharon	Nelson	American Heart Association	Program Initiatives Manager
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Shelli Jo	Ness	Southeast Utah Public Health Department (SEUHD)	Public Health Educator
Tom	Keane	Division for Heart Disease and Stroke Prevention (CDC)	Acting Policy & Partnerships Team Lead
Tracy	Altman	University of Utah Health Plans	Manager, Government Programs
Violet	Brown	Salt Lake County Health Department (SLCoHD)	Health Educator
Zachary	Miller	Association for Utah Community Health	Integrated Care Coordinator

List respects participant choice of whether to share contact information.

If you want to go fast, go alone. If you want to go far, go together.

—African proverb