Advancing Million Hearts®

AHA and Heart Disease and Stroke Prevention Partners Working Together in South Carolina

September 1, 2020
Virtual Event
Meeting Summary



NATIONAL FORUM FOR HEART DISEASE & STROKE PREVENTION

Million Hearts®

American Heart Association.

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Meeting Summary

Goal: The goal of the meeting was to engage state and community partners in developing and implementing coordinated hypertension management strategies across Federally Qualified Health Centers (FQHC) in South Carolina.

Objectives:

1. Increase awareness of Million Hearts® strategies and activities for 2020
2. Develop strategies for increasing patient engagement and activation in hypertension self-management
3. Identify opportunities to collaborate with community partners to address patients' social and economic needs
4. Develop strategies to maximize patient visits to support hypertension management

Outcome:
Attendees will initiate plans to align and sustain efforts to manage hypertension in South Carolina (SC).

Overview
On September 1, 2020, 84 representatives from 27 health organizations across SC came together to develop strategies for managing hypertension within the patient population of FQHCs. This was the 11th Advancing Million Hearts® event and the first to be held virtually.

The meeting was designed to help participants increase their knowledge of existing hypertension efforts, initiate opportunities for collaboration and share success and lessons learned with peers. Speakers provided national, state and local perspectives on cardiovascular disease prevention and management. This included tools and resources available through the Million Hearts® initiative as well as hypertension initiatives through the South Carolina Primary Health Care Association, the American Heart Association and the SC Department of Health and Environmental Control. Local partners presented examples of strategy implementation in local clinics.

Meeting attendees chose one of the following three breakout sessions in which to participate:

Session 1: Increasing patient engagement in hypertension self-management
Session 2: Collaborating with community partners to meeting patients' social and economic needs
Session 3: Maximizing patient visits for support hypertension management

Most attendees (60%) participated in Session 1; 26% participated in Session 2 and 14% participated in Session 3. Session participants were able to share information about their organizations' efforts and begin to identify potential alignments. Following the sessions, each group provided an overview of key takeaways which included the following themes:

- Patient feedback is critical to understanding needs, developing trust, and engaging in self-management of chronic conditions
- Creating opportunities for partners to share best practices and resources is key to the success of a statewide hypertension management strategy
- Community health workers play an important role in engaging patients and linking them to needed supports

- Expanding partnerships to include those addressing behavioral health and social determinants of health

The South Carolina Primary Health Care Association will be leading next steps with the Federally Qualified Health Centers. The following steps were shared by Sarah Cockrell, Manager of Clinical Quality Improvement

- Have a FQHC apply and be recognized as a Hypertension Control Champion
- Use the SCPHCA training and technical assistance infrastructure by means of the quarterly clinical networks and annual clinical network retreat as avenues to reconvene and move the work forward
- Leverage Azara, the population health tool platform through the HCCN, to track clinical quality measures
- Partner with SCDHEC Division of Diabetes and Heart Disease to assess opportunities to facilitate virtual gatherings of statewide partners
- Utilize the readily available Million Hearts materials for quality improvement benchmarks and standards to continue to move the needle on hypertension control and chronic disease management

Approximately 50 of the 84 participants responded to the post meeting evaluation survey. Feedback indicated that the information presented was very useful or somewhat useful in addressing the meeting's objectives. Additionally, 60% of respondents shared that they had identified a new partner with which to connect. Overall, participants seemed to appreciate the opportunity to learn about existing efforts and network with colleagues. The Post-Meeting Evaluation Summary is shared later in this document.

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

The following responses were shared by meeting participants:

- *To help promote health outcomes for all communities and to see how we can all collaborate to achieve collective goals!*
- *Making an impact in the community.*
- *The knowledge that 80% of heart disease and preventable and helping make people aware of this*
- *I am most excited about the impact on people lives.*
- *The impact collaborations can have to improve prevention and management of heart disease and stroke.*
- *It excites me to have the opportunity to participate in multiple projects that can impact heart and stroke health across many communities.*
- *Helping people live longer, healthier lives!*
- *Funding lifesaving research/techniques and working with our community to identify area of needs*
- *Making an impact in communities who are in most need for solutions that will improve their overall health.*
- *Improving the health of SC and making it a great place to live.*
- *Working to help make communities healthy.*
- *Hearing success stories from people who are working to improve their health and the health of others.*
- *I get the opportunity to influence what others know about such prevalent chronic diseases and conditions. It is not just enough to have knowledge myself, but to share that knowledge and encourage a ripple so that others share that knowledge as well.*
- *Ability to mobilize community health workers and other community change agents in this work.*
- *Being armed with valuable information and resources related to heart disease and stroke prevention to share with communities and other Community Health Workers in SC.*
- *The potential to create positive behavior change among individuals that lead to better choices and improved physical and mental well-being.*
- *Driving changes to policies and systems to reduce cardiovascular health disparities*
- *Developing protocols and policies that promote quality care.*
- *Helping people change their behaviors before they develop any heart problems.*
- *To learn new ways to close our members care gaps and improve their health.*
- *I like to encourage people to make changes and when they do, no matter how small, I am proud of them.*
- *Educating members, encouraging them to value and participate in their own healthcare.*

Agenda

Time	Agenda Item/Topic	Speaker/Facilitator
8:15-8:45 am	**Pre-meeting Partner Networking** Participants will be randomly assigned into virtual rooms to network	**John Bartkus, PMP, CPF** Principal Program Manager, Pensivia
8:45-8:50 am	**Please Join no later than 8:50 am** Verify Audio/Video working And Vevox App setup on your phone	
9:00 – 9:10 am	**Welcome** **Overview of the Day**	**Laura King** Director of Public Health, American Heart Association **Julie Harvill** Operations Manager, Million Hearts® Collaboration
9:10 – 9:35 am	**Engagement & Introductions** Name, Organization, and Role *Watch screen for name – alphabetical order*	**John Bartkus**
9:35 – 10:05 am	**Million Hearts® 2022 Update** **Q & A**	**Laurence Sperling, MD** Executive Director, Million Hearts® **Lauren Owens** Public Health Analyst, Million Hearts®
10:05-10:40 am	**SC Hypertension Initiatives and Resources** • South Carolina Primary Care Association • American Heart Association • South Carolina Department of Health & Environmental Control **Q & A**	**Katherine Plunkett, MPA** Sr. Manager, South Carolina Primary Health Care Association. **Vonda Evans** Community Impact Director, American Heart Association **La'Shanda Wood** Health Systems Specialist, South Carolina Dept. of Health & Environmental Control
10:40-10:45 am	**Stretch Break**	**Jen Childress, MS, MCHES** Jenspiration, Inc. Senior Public Health Consultant, National Forum for Heart Disease & Stroke Prevention
10:45-11:00 am	**Patient Engagement in Hypertension Self-Management** **Q & A**	**Daniel T. Lackland Dr. P.H.** Medical University of South Carolina
11:00-11:15 am	**Collaborating with Community Partners to address patients social and economic needs** **Q & A**	**Tricia Richardson** CEO, SC Thrive

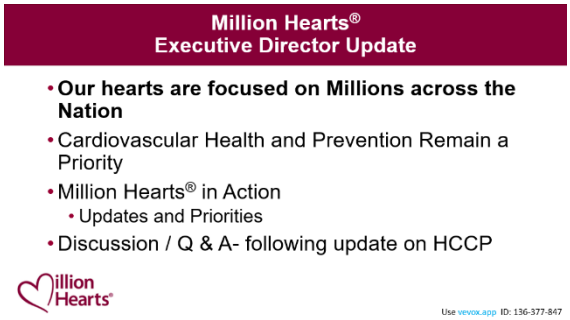
11:15-11:45 am	**Maximizing patient visits to support hypertension management** **Q & A**	**Crystal A. Maxwell, MD, MBA, FAAFP** Chief Medical Officer/Family Physician, Sandhills Medical Foundation, Inc. **Edward Behling** Chief Medical Officer, HopeHealth **Tammy Garris** Clinical Data Integrity Controller, HopeHealth
11:45-12:00pm	**Integrating Community Health Workers into Team-based Care** **Q & A**	**Andrea Heyward** Systems Integration Manager, Center for Community Health Alignment and the Community Health Worker Institute
12:00-12:30 pm	**Lunch** (and additional individual networking opportunities through Zoom private chat)	
12:30-12:35	**Physical activity break**	**Jen Childress, MS, MCHES** Jenspiration, Inc. Senior Public Health Consultant, National Forum for Heart Disease & Stroke Prevention
12:35-1:55 pm	**Breakout Introduction** **Breakout Sessions** • Patient Engagement • Community Supports • Maximizing patient visits	**John Bartkus**
1:55-2:05 pm	**Break**	
2:05-2:35 pm	**Group Report Outs**	**John Bartkus**
2:35-2:45 pm	**Summary of Common Themes/Strategies**	**Sharon Nelson, MPH** Program Initiatives Manager**,** Million Hearts® Collaboration
2:45-2:55 pm	**Next Steps**	**Sarah Miller Cockrell, MPH** Manager of Clinical Quality Improvement, South Carolina Primary Health Care Association
2:55-3:00pm	**Adjourn**	**John Clymer** Executive Director, National Forum for Heart Disease and Stroke Prevention

Presentations:

The following are highlights of presentations shared by meeting participants. The full presentations can be found at the end of the report.

Million Hearts® 2022 Update

Laurence Sperling, Executive Director, Million Hearts®
Division for Heart Disease and Stroke Prevention, CDC



Impact of Pandemic on Cardiovascular Care

Emergency physicians are seeing declines in the number of patients arriving with cardiac problems.

Current Challenges/Concerns

- 118 million Americans living with hypertension
- Disruption of ambulatory care
- Need for medication access and adherence
- Impact on lifestyle implementation
- Disruption of cardiac rehabilitation

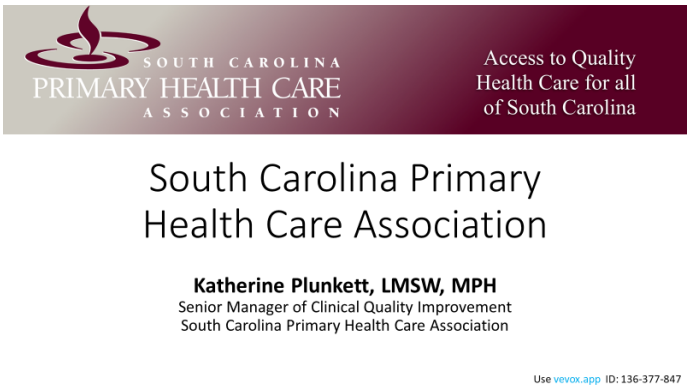
Million Hearts® Updates

- CDC Foundation Campaign
- Million Hearts 1.0 Addendum
- Hypertension Control Champions
- Cardiac Rehabilitation Think Tank
- AMA/ AHA Scientific Statement SMBP
- AMA validatebp.org
- JCRP & JAMA Cardiology invited commentaries
- CMS promotes V-BID in Final Payment Notice for 2021
- Reinvigorating 100 Congregations
- Updated Hypertension Control Change Package
    - Includes 253 tools from 87 organizations
    - Capitalizes on 7 years of MH Hypertension Control Champions

- Features more self-measured blood pressure monitoring (SMBP) resources
- Explores potentially undiagnosed hypertension
- Added new strategies that focus on chronic kidney disease (CKD) testing and identification
- Provides more patient supports for lifestyle modifications

South Carolina Primary Health Care Association

Katherine Plunkett
Senior Manager of Clinical Quality improvement



Training and Technical Assistance Infrastructure

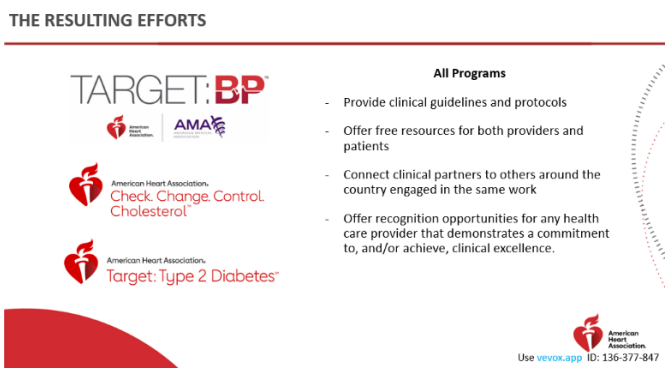
- Clinical Networks
- Technical Assistance
- Annual Clinical Network Retreat
- SCPHCA First Thursdays CQI Webinar Series

Clinical Quality Initiatives

- Chronic Disease Management
- Care Coordination with the Medical Neighborhood

American Heart Association Hypertension Initiatives

Vonda Evans, Community Impact Director

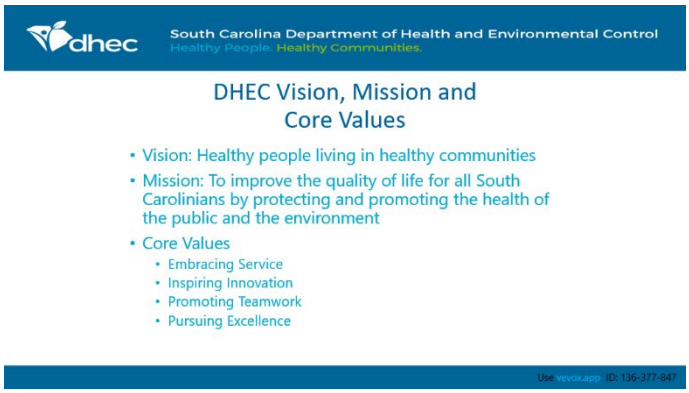


AHA Quality Improvement Tools

- Target:BP
- Check.Change.Control
- Target: Type 2 Diabetes
- Healthcare System Recognition Programs

<u>South Carolina Department of Health and Environmental ControlLouisiana Partner Hypertension Initiatives</u>

La'Shanda Wood, Health Systems Specialist
Division of Diabetes and Heart Disease Management



Approach to Hypertension Management

- Health Systems Interventions
- Clinical-Community Linkages
- Provider Engagement

<u>Strategies for increasing patient engagement and activation in hypertension self-management</u>

Daniel T. Lackland
Medical University School of South Carolina

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

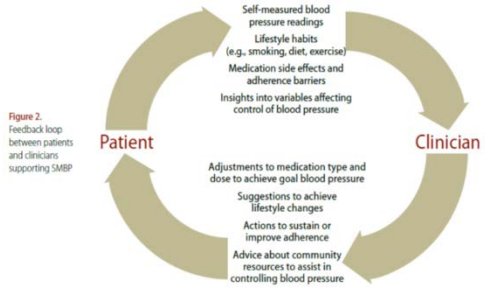


Figure 2. Feedback loop between patients and clinicians supporting SMBP

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

Collaborating with Community Partners to Address Patient and Social Economic Needs

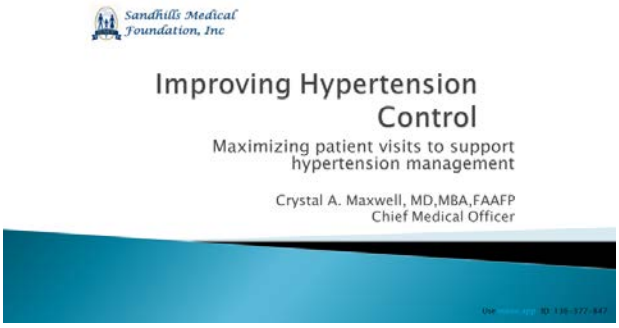
Tricia Richardson, CEO
SC Thrive

Overview of Thrive Hub

1. CommUnity
2. CollabTools
3. Learning Nook
4. WorkStation

Maximizing Patient Visits to Support Hypertension Management

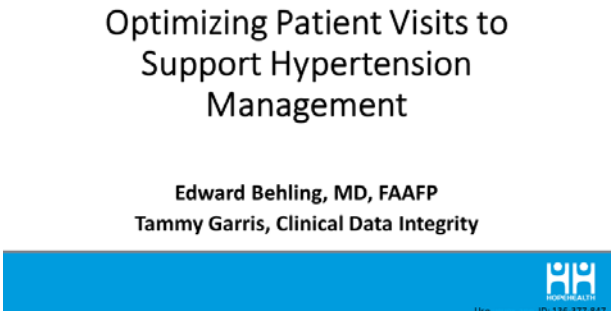
Crystal A. Maxwell
Chief Medical Officer, Family Physician, Sandhills Medical Foundation, Inc.



Strategies for improving hypertension control

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

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



Strategies for optimizing patient visits to support hypertension managements:
Staff Education

- Refresher trainings
- Implement Staff trainings/new education

Program Creation/Enhancements

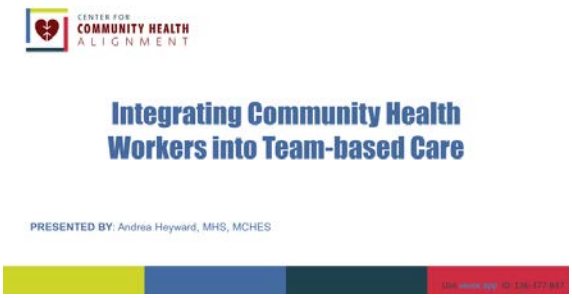
- Implement programs that focus on identifying causes of increased BP

Patient Education

- Educate patients on symptom recognition and self-management

Integrating Community Health Workers into Team-based Care

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



Community Health Workers play multiples roles and can help address the following issues

- Workforce shortages
- Move to value-based care
- Recognition of importance of addressing social determinants and non-medical needs
- Ability to fill gaps in care not filled by others as part of the care team

Breakout Group Discussions:

Meeting participants selected one of the following discussion sessions in which to participate.

Group	Topic	Co-Facilitators	Notetakers
1	Increasing patient engagement in hypertension management	Crystal Kirkland Nathaniel Patterson La'Shanda Wood Vonda Evans Dom Francis Nora Farrell	Valerie Bridges Kacie Kennedy Kelly Wilkins
2	Collaborating with community partners to address patients social and economic needs	Brennan Meagher John Clymer Kayla Kranenberg Sarah Cockrell	Laura King Annie Thornhill
3	Maximizing patient visits to support hypertension management	Katie Schumacher	Sharon Nelson

The following notes were taken during each discussion.

Group 1: Patient Engagement in Hypertension Self-Management

Breakout Group Questions

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

Facilitator guidance: Lead the group through these five key questions. You have 75 mins from 12:40 – 1:55pm EDT. The subitems are only ideas/examples of specific questions to keep the conversation moving.
Change or add questions as desired – to keep to flow going on the five questions and leave 5 mins at end for individual take-aways.

Group Discussion (Focused on Five Key Questions):

1. What's **WORKING WELL**? (~15 mins)
   a. *What are you doing now to increase patient engagement – and what are the results?*
   b. *Where are examples of things working well – that we might repeat/leverage/expand?*

2. What are the **KEY CHALLENGES**? (~15 mins)
   a. *What are challenges/barriers to patient engagement?*
   b. *How have you continued engaging patients through telehealth?*

3. How might we **ADDRESS THESE CHALLENGES**? (~15 mins)
   a. *Which of these challenges can and should we tackle?*
   b. *How can we address those challenges?*

4. What other **OPPORTUNITIES** do we have? (~15 mins)
   a. *What did you learn today that might influence your direction or support you?*
   b. *Where can we magnify impact by working together?*
   c. *Are there common/shared strategies on which we can focus as a group?*
   d. *What tools/resources/process do we need to implement these strategies?*

5. What do we choose to **DO NEXT**? (~10 mins)
   a. *What Actions are we choosing to take?*
   b. *How can we ensure these efforts are sustained? How do we keep the momentum going?*

Individual Take-aways: (~5 mins)

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

Group 1A Report-Out

Question 1: WORKING WELL

Running reports helps, data, different areas involved in patient care helps increase trust, intentional effort meaningful dialogue to engage patients and families, collaborative synergy with statewide agencies is making a huge difference in FQHC, increased resources help with this, staff helping people in rural areas helped get patients more engaged, health care not being 9-5, events around the state and member advisory committee helps us hear what works, repetition builds trust.

Question 2: CHALLENGES

Patient and family engagement, involving other areas of the practice would help, communicating effectively, identifying the challenge on why patients are not fully engaged – what is that reason don't make assumptions, challenge of patient understanding and feeling comfortable to ask questions and not really being up to date on health literacy. Not having enough funds and turnover of staff. The patient's age and not having trust with provider and instead listening to family members. Patients are fearful of what the news will be, so they do not pursue. Language barrier and translation services do not always help. Theft – medicines stolen.

QUESTION 3: ADDRESSING CHALLENGES

Giving bags for medications so they can bury if they are homeless. Give baggies to patients so they bring meds to their appt. utilize community health workers, if we cannot reach patients as means of communication, because so many do not have numbers. Utilize data from UHR and find the time to see what steps could be made to move forward. Provide transportation, sliding fee for medication, partner with MUSC for diabetic patients. Best chance network with ACS.

QUESTION 4: OPPORTUNITIES

Educational opportunities, impact of care to patients, more training for providers in clinics and getting that to patients. Engaging case works and those that manages patients' meds, appts. Use the resources that we have available.

QUESTION 5: NEXT STEPS

Have vans Testing patients where they are with COVID right now, but then the vans will be used to go into communities to meet the patients where they are – if they cannot come to us. Following up with our locations to get them signed up for different tools and address those challenges. Really surviving provider influences around social determinants of health and sustainability. Consistently sharing resources with what works and what does not work. Do not recreate the wheel – use your peers and what works with them.

The following individuals registered to participate in this breakout discussion:

Cindy Causey
Crystal Kirkland
Jacqlyn Atkins
Kimberly Fulford
Kristian Myers
Lisa Linton
Nathaniel Patterson
Rosa M. Wilson
Valerie Bridges
Vicki Young

Karen Southard
Laurence Sperling
Michele Guscio
Morganne Shook
Patty Nodine

Group 1B Report-Out

Question 2 CHALLENGES:

- Patients scared to come into clinics or visit pharmacies to pick up prescriptions.
- Issues with compliance stemming from less in-person connections with providers.
- Responding to the needs of multi-generational communities.
- People often do not realize that other folks are encountering similar problems – they are not alone.

Question 4: OPPORTUNITIES:

- COVID has highlighted the importance of community health workers. Prioritizing making sure these workers have all the appropriate resources they need.
- Utilizing SC Thrive with providers.
- Listen to our patients!
- Utilizing community health worker trainings through the Center for Community Health Alignment at USC.
- Continue to communicate with patients about the safety precautions being taken by the office so they will continue to feel safe to visit your site.

Question 5: NEXT STEPS

- Check in with the group in a month to see where we stand with items that we want to implement from today.
    - have our ideas been implemented?
    - what challenges have we faced?
    - does anyone need any brainstorming help to meet needs with their patients?
- Continue to make time for collaborative meetings within teams and with community partners.
- Consider what are the patient's goals? not the goals of the provider. including this in the beginning of every meeting.
- Be very intentional in our interactions with patients and community members to ensure the greatest impact.
- Consider more community events with incentives when it becomes more appropriate.

The following individuals registered to participate in this breakout session:

Angela McCall
Carolyn Fulmore
Cheri Laffre
Dan Kass
Julie Smithwick
Kacie Kennedy
Kimberly Rawlinson
La'Shanda Wood
Rachel Nichols
Rhonda Hill
Tannesha Clements
Vonda Evans
Keisa Hill
Latasha Sullivan
Madison Hall
Reid Platt

GROUP 1C REPORT OUT

Question 1: WORKING WELL

- Outreach to members in key areas from quality team- once in touch, they are willing to communicate
- Assist with issues as conversation flows to build trust
- Develop Trust
- Providers send referral in system and connect with patients and discuss strategies to improve health overall
- Chronic care management phone calls for patients that choose to enroll – monthly calls – to keep engagement, see most at wellness visits to maintain communication – be aware of in person visits to make a face to face check in- being a direct line of communication to their doctors

Question 2: CHALLENGES

- Getting in touch with them, opening conversation and continuing
- Comfort level of talking about health
- Develop Trust
- Quality of BP cuffs sent to CHF/Availability of BP cuffs
- Engagement – getting people to WANT to participate
- Some patients have to pay for chronic care management calls and cannot afford
- Isolation, Transportation barriers
- Limited Telehealth
- COVID – people not showing up for appts or care

Question 3: ADDRESS CHALLENGES

- Development of Trust – Ongoing Process, consistent, listening to needs, meeting patients where they are, what is their level of understanding
- Meet face to face, follow up, show them you care, continue the communication
- Phone brings new challenges so keeping smile on face in discussion, making sure you are open listening and personalize conversation
- Outside of building/facility vital care measurements/equipment
- Blood Pressure readings outside prior to receiving medication refills
- Asking Questions so they feel as they are solving their own problems rather than be told – training for clinical staff – motivational interviewing

Question 4: OPPORTUNITIES

- Dietary prescriptions for healthier food, cooking classes
- Engage pharmacists in BP management

Question 5: NEXT STEPS

- Investigate Motivation Interviewing training to implement across the state, clinical staff, pharmacists, more
- Peer Groups to continue conversations and move the needle forward

- Investigate the opportunities for more prominent utilization of the community health worker model in our communities – bridging community and health care teams, BIG key to TRUST – know the community they live in – Find that Well Known person in the community to be the driver
- Finding out where our members are at? What is the disconnect with what the providers are doing?
- Do more motivational interviewing with patients, more open-ended questions, engage them more, more prep prior to call
- How can we openly communicate/collaborate across channels/organizations? Who else needs to be in the room? What other conversations need to be had?
    - it would be helpful if more systems talked with one another
    - Community Network meetings – once a month that offers organizations chance to share what they are doing in community and discover ways to connect
- Investigate Motivation Interviewing training to implement across the state, clinical staff, pharmacists, more
    - Peer Groups to continue conversations and move the needle forward
- Investigate the opportunities for more prominent utilization of the community health worker model in our communities – bridging community and health care teams, BIG key to TRUST – know the community they live in – Find that Well Known person in the community to be the driver

The following individuals registered to participate in this breakout session:

Audrey Jackson
Austin Kinard
David Robertson
Dom Francis
Elizabeth Sorg
Ellen Langan
Kelly Wilkins
Michelle Helton
Millie Grooms
Nora Farrell
Rita Jones
Shauna Hicks
Susan Moxley
Yarley Steedly
Cantress Brown
Natasha Colvin

Group 2: Collaborating with community partners to meet patients' social and economic needs

Breakout Group Questions

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

Facilitator guidance: Lead the group through these five key questions. You have 75 mins from 12:40 – 1:55pm EDT.

The subitems are only ideas/examples of specific questions to keep the conversation moving.

Change or add questions as desired – to keep to flow going on the five questions and leave 5 mins at end for individual take-aways.

Group Discussion (Focused on Five Key Questions):

1. What's WORKING WELL? (~15 mins)
    a. With which community partners are you currently collaborating - and what are the results?
    b. How do you use the PCMH model to support patients' social and economic needs?

2. What are the KEY CHALLENGES? (~15 mins)
    a. What challenges/barriers do we have to overcome - in order to collaborate with community partners to meet patients' social and economic needs?
    b. How does collaborating with community partners change as a result of Covid-19
?

3. How might we ADDRESS THESE CHALLENGES? (~15 mins)
    a. Which of these challenges can and should we tackle?
    b. How can we address those challenges?

4. What other OPPORTUNITIES do we have? (~15 mins)
    a. What did you learn today that might influence your direction or support you?
    b. Where can we magnify impact by working together?
    c. Are there common/shared strategies on which we can focus as a group?
    d. What tools/resources/process do we need to implement these strategies?

5. What do we choose to DO NEXT? (~10 mins)
    a. What Actions are we choosing to take?
    b. How can we ensure these efforts are sustained? How do we keep the momentum going?

Individual Take-aways: (~5 mins)

- What new community partners can I partner with to address patients' social and economic needs?
- What staff member would take the lead on this new community partnership?

- What would it take to engage with more community partners in my health centers' service area and with statewide partners?
- How can I address barriers might prevent me from collaborating with community partners to address patients social and economic needs?
- What are two things I can implement tomorrow to increase community partnerships?

GROUP 2A REPORT OUT

Question 1: WORKING WELL

- Community Health Centers: Making sure that community has what is needed, (example: PPE), addressing short term urgent needs and stress among healthcare work force
- DHEC: Provide a farmer's market to patients that need access to healthier foods (SNAP accepted)
- USC Med School: residency program that is allowed organization to open a new site
- Mobile RX app to make it easier/more convenient for patients to fill prescriptions
- Working with community providers to educate them on availability of telehealth and other available resources (Aunt Bertha)
- Screening tools used to evaluate SDOH
- Primary Care Association uses prepare model for evaluation
- Connecting to and taking full advantage of community resources—when and where we know they exist; screening and referring based on social determinants needs

Question 2: KEY CHALLENGES

- Lack of awareness of existing organizations and work being done which can lead to replication of efforts rather than collaboration (also presents a potential opportunity to expand to better reach target population across the state) Possible solution could be resource mapping of partners/resources/services
- Working in silos
- Money – community partners need more resources but lack of resources can create barriers for patients that need to receive care (potential solution- better leverage existing/new partnerships)
- Providers – knowledge of what's available and what isn't, what medications are covered/on preferred drug list
- Individuals that previously worked in the field no longer able to be out in the community
- Transition to virtual work
- Competing priorities
- Understanding what unknown resources exist and how to best take advantage of those (communication), especially among drawing down on provider and patient coverage (what is covered, who can provide, etc)

Question 3: ADDRESS CHALLENGES

- Improving communication addresses multiple challenges
- Find solutions for addressing these challenges during a pandemic (virtual work)
- Resource awareness
- Relationship/network building
- Map and communicate existing tools that would identify plan coverage
- Identify lowest hanging fruit, focus on communication (since it addresses all challenges), know that overlap of resources can mean areas of focus and improvement

Question 4: OPPORTUNITIES

- American Heart Association educational resources
- Community Health Workers are key, learning more about their work and ways to convene
- What partners not present today can help serve as a bridge?
- Reimbursement strategies (expanding who can be reimbursed for existing coding so that more than one kind of provider can provide certain services, mapping out which carriers are reimbursing which kind of provider for which service, some of these issues can be addressed by granting pharmacists provider status)

- Local champions can be helpful with pushing these strategies forward
- Communication, additional community resources (esp CHW), and expand provider and patient coverage

Question 5: NEXT STEPS

- Loop in BCBS as the primary provider in South Carolina
- Identify opportunities to do more (expand definitions of who can provide existing care)
- Identify who is in the position to advocate for more
- Map existing resources
- Convene community resources to build relationships (and trust), map & communicate existing resources, identify areas where we can advocate for additional resources.

The following individuals registered to participate in this breakout session:

Annie Thornhill
Beth Graham
Brennan Meagher
Debra Simmons
John Clymer
Julie Harvill
Mary Newman
Sarah Banyai
Tiffany Hills
Melinda Postal
Mike Lionbarger

GROUP 2B REPORT OUT

Question 1: WORKING WELL

Figuring out opportunities to reduce duplication and finding ways to collaborate. Community Health Worker Institute. Small network within public health in SC- helpful and easy to make connections. If you don't have connection, easy to make that network.

Department of Health at the state level. Department of Social Services- running pilot programs for those with unmet healthcare needs. Care Coordination. Hospital association. Alliance for Health SC. DPP-Diabetes. SC Agricultural Worker Health Program-provide access to care for agricultural workers in the state.

Outcomes of collaboration: Overall helpful. In community organizing, marathon not sprint. Figuring out how to bring multiple priorities together. Leveraging resources to make the most impact for our community.

CDC- Work mostly with national orgs. Funds 50 states for heart disease research work- all states doing partnership work. YMCA/YUSA-establish blood pressure self-monitoring program- couple hundred Y's across the US.

CEO's of the PCA Board- guide and direct. Make sure that any way that can collaborate, open to. Not necessary to re-create wheel and waste resources.

Question 2: KEY CHALLENGES

Competing priorities is a large barrier. How do we effectively and strategically align.

COVID-19. Patient hesitance to come into the office. Will put it off if they can. Let patients know it is safe/changes that have been made to keep them safe. Having patients delay resulting in rapid heart attack and strokes.

Still recruiting practitioners. Many see as additional work- lack of capacity because many are stretched so thin. Working to identify creative ways to provide assistance.

TIME. All Quality Improvement initiatives take time. When something like COVID occurs, taking some else on (even if you see the benefit) may not be feasible. Have to have benchmarks but not a quick fix.

Everything moving to virtual. It's a lot harder to make personal connection/see spaces virtually. So much of day to day is creating relationships. Challenge to not have the same personal connection that has been the norm (site visits/person to person meetings).

Easier to address physical need. Much more challenging to address social/economic with patient. Sometimes primary reason for visit has nothing to do with social/economic need.

Question 3: ADDRESS CHALLENGES

Patients are hesitant to come into the office. Using telehealth and other alternative care coordination approaches. Although it is not the same, it is better than nothing and you can stay in tune with the patient's health.

Giving resources on blood pressure cuff size. Best practices. Disseminating information. Validating BP machines.

Quality Improvement initiatives- creating realistic expectations. Ex- extending timeline on programs. Ultimately creates sustainability. Individuals can see the real impact of the program- not just one quick cycle/a check box. Can be useful and put into practice.

Question 4: OPPORTUNITIES
Updates from Community Health Worker Group Institute.

Million Hearts Initiative. How many resources are available? Quality improvement plan and breaking it down further. Implement where you are. No need to reinvent the wheel.

How can our organization fit in to what is already happening and make an impact? How can we align to complete Million Hearts® goals?

Avoiding duplication of efforts- how do we align.

Under-utilized resource: MCO Care coordinators. Opportunities for partnership.

Fully understanding what 'lane' each partner is in. Helpful to hear when they are aligning to see where our orgs can align to move control of chronic disease management forward.

Importance of self-monitoring BP at home (especially during COVID). Resources to help patients self-monitor are really important.

Question 5: NEXT STEPS
Don't let this training be a one-time thing. Make sure we move this forward and re-convene/re-assess.
Leveraging opportunities for grants for TACM program.

Monitoring data. Checking regularly to ensure improvement and continuing to follow it. Providing education and communicating to staff and clinical team where you are to get buy-in.
State-wide Million Hearts coalition to work on initiatives. Was successful because there was structure to work on larger state-wide issues. Has been effective in other Utah with Million Hearts.

The following individuals registered to participate in this breakout session:

Andrea Heyward
Annie Brown
Darnai Williams
Katherine Plunkett
Kayla Kranenberg
Kim Hale
Laura King
Michael Sells
Sarah Cockrell
Tom Keane
Donna Mack

Group 3: Maximizing Patient Visits to Support Hypertension Management

BREAKOUT GROUP QUESTIONS

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

Facilitator guidance: Lead the group through these five key questions. You have 75 mins from 12:40 – 1:55pm EDT.
The subitems are only ideas/examples of specific questions to keep the conversation moving.
Change or add questions as desired – to keep to flow going on the five questions and leave 5 mins at end for individual take-aways.

Group Discussion (Focused on Five Key Questions):

6. What's **WORKING WELL**? (~15 mins)
    a. *What strategies to maximize patient visits are you currently employing - and what are the results?*
    b. *How do you continue high-impact visits by the mode of telehealth?*
    c. *Where are examples of things working well - that we might repeat/leverage/expand?*

7. What are the **KEY CHALLENGES**? (~15 mins)
    a. *What challenges/barriers do we have to overcome in order to maximize patient visits?*
    b. *How does COVID-19 impact the vision of high-impact visits?*

8. How might we **ADDRESS THESE CHALLENGES**? (~15 mins)
    a. *Which of these challenges can and should we tackle?*
    b. *How can we address those challenges?*

9. What other **OPPORTUNITIES** do we have? (~15 mins)
    a. *What did you learn today that might influence your direction or support you?*
    b. *Where can we magnify impact by working together?*
    c. *Are there common/shared strategies on which we can focus as a group?*
    d. *What tools/resources/process do we need to implement these strategies?*

10. What do we choose to **DO NEXT**? (~10 mins)
    a. *What Actions are we choosing to take?*
    b. *How can we ensure these efforts are sustained? How do we keep the momentum going?*

Individual Take-aways: (~5 mins)

- *What new strategy for maximizing patient visits have I heard about?*
- *What new partners have I identified today with whom I can work to further my/their goals?*
- *What are two things I can implement tomorrow to increase high-impact visits at my health center?*

GROUP 3A REPORT OUT

Question 1: WORKING WELL

- Internal referrals to behavioral health
- Self-measured BP monitoring
- BP and glucose monitoring (TACM – 100 patients)
- Coordinate with home health services to monitor vital signs
- EMR contains a "problem list"
- Gaps in care measures should be flagged (BP in control, medication, BMI)

Question 2: KEY CHALLENGES

- Reimbursement for telehealth visits beyond pandemic
- Not all patients have BP monitors at home
- Get patients to come back for follow up visits: may not see the importance of it, conflicts with work schedule
- EMR flags are not consistently addressed
- Lack of access to affordable healthy foods

Question 3: ADDRESS CHALLENGES

- Supply BP monitors to each patient
- Receive BP readings in real time
- Certification for team-based training for standard protocol
    - Incentive for clinics to receive training certification, % of patients that have BP monitors
- Payors to reimburse for BP monitors
- Physicians refer to counseling for stress management/Behavioral Health Specialist referral back to physician for BP management
- Nutrition counseling during physician visits, education on healthy cooking provided through centers

Question 4: OPPORTUNITIES

- Providing farmers' markets at clinics
    - Reimbursement from SNAP benefits

Question 5: NEXT STEPS

- Schedule visits to meet all needs of the patient (behavioral health, nutrition, medication follow up)
- Certification for team-based training for standard protocol
- Incentive for clinics to receive training certification, % of patients that have BP monitors
- Partnership with behavioral health to support stress management and BP control
- Coordinate with home health services to monitor vital signs
- Need reimbursement for key elements such as BP monitors
- EMR can be effective tool if used properly

The following individuals registered to participate in this breakout session:

Daniel Lackland
Julia Schneider
Katie Schumacher
Michele James
Miriam Patanian
Nancy P. Parker
Princess Davis
Sharon Nelson
Terrie Pieper
Tracie Thigpen
Stephanie Hinton

Post Meeting Evaluation:
Advancing Million Hearts: American Heart Association and Heart Disease and Stroke Prevention Partners Working Together in South Carolina

September 1, 2020

Meeting Attendees: 84
Survey Responses: 50

The majority of survey respondents thought the meeting was very useful or somewhat useful in meeting its objectives of:

- *Increase awareness of Million Hearts® strategies and activities for 2020*
  - Very useful: 91%
  - Somewhat useful: 9%
- *Develop strategies for increasing patient engagement and activation in hypertension self-management*
  - Very useful: 81%
  - Somewhat useful: 17%
  - Not very useful: 2%
- *Identify opportunities to collaborate with community partners to address patients' social and economic needs*
  - Very useful: 79%
  - Somewhat useful: 21%
- *Develop strategies to maximize patient visits to support hypertension management*
  - Very useful: 82%
  - Somewhat useful: 15%
  - Not very useful: 2%

60% of survey respondents plan to connect with new organizations as a result of this meeting. Including:

- SC Thrive (13)
- AHA (5)
- USC-CHW program (4)
- FQHCs (3)
- Centers for community health alignment (2)
- Rural Health (2)
- NF
- SCPHCA
- MUSC
- SCDHEC
- MH Recognition Program
- AMA
- MPA
- BP program
- Prescription food delivery
- Pharmacists
- American Cancer Society
- NACDD

After attending the meeting, respondents said they plan to explore CVH resources related to:

- SMBP (6)
- BP training for accurate measures (3)
- Home health monitoring (2)

- Sharing new information/resources (2)
- Behavioral counseling for elevated BP and A1C levels
- Clustering patient's preventative/health services at one visit
- Work with other organizations to improve communication
- Communication on stress reduction
- Communication with PCP
- CHWs
- Using SC Thrive
- Dr. Maxwell's tools for hypertension control
- Mobile units for patient engagement

Participants felt the most valuable part of the meeting was:

- Networking/discussion (16)
- Breakout sessions and report outs (13)
- Speakers (6)
- Information (2)
- Out of clinic BP measurement (2)
- COVID response
- Engaging patients for better outcomes
- Overall goal of reducing/sustaining healthy BP outcomes

Participants felt the least valuable part of the meeting was:

- Breakout reports seemed too long and unorganized (3)
- Networking at the beginning (2)
- Exercise (2)
- Technology
- Length of breakouts
- Too quick
- Integrating CHWs into team-based care
- Length and virtual nature

Suggestions for the future:

- Wished it was in person (2)
- Needed access to links
- More time to network
- Structured socializing
- Extra break/stretch activity in the morning
- Larger breakout room size
- More interaction with speakers

Attendee List:

Name	Position	Organization	Email Address
Andrea Heyward	Systems Integration Manager	Center for Community Health Alignment	heywarda@mailbox.sc.edu
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Courtnay Thompson	Market President	Select Health of South Carolina	
Isaac Goldszer		Medical University of South Carolina	
Jerome Corley			
Jimmy Ellis	Manager of Member Services	South Carolina Primary Health Care Association (SCPHCA)	
Johnese Bostic	Women's Health Informatics Analyst	South Carolina Primary Health Care Association (SCPHCA)	
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Sharon Black	Behavior Health Consultant	HopeHealth	

1

Welcome and Opening Remarks

LAURA KING
Director of Public Health
American Heart Association

2

Objectives for Today

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

3

Advancing Million Hearts® - South Carolina Planning Committee

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

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

4

Overview of the Day

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

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Agenda

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

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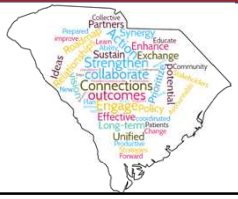
What does Success Look Like?



7

Engagement & Introductions

JOHN BARTKUS
Principal Program Manager
Pensivia

Event Facilitator

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Engaging throughout the day

zoom Meeting

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

vevox

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

9

Engaging throughout the day

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Audience Engagement

Join at vevox.app

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Million Hearts®

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10

Join: vevox.app ID: 136-377-847 | Enter Text and Press Send

Where are you joining from today?

Million Hearts®

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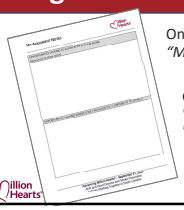
Alignment and Connections



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

Opportunities I found to:
* Align with My Organization's work
* Align with Others' work

Million Hearts®

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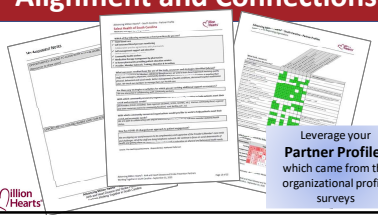
Alignment and Connections



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

Million Hearts®

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Introductions

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

Million Hearts®

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Million Hearts® 2022 Executive Director Update

LAURENCE SPERLING, MD, FACC, FACP, FAHA, FASPC
Executive Director, Million Hearts®
Division for Heart Disease and Stroke Prevention, CDC
Center for Clinical Standards and Quality, CMS
Katz Professor in Preventive Cardiology
Professor of Global Health
Emory University

Million Hearts®

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Disclaimer/Disclosure

The opinions expressed by the speaker do not necessarily reflect the opinions of the US Department of Health and Human Services, the Public Health Service, the Centers for Disease Control and Prevention, or the Center for Medicare and Medicaid Services.

Dr. Sperling has no conflicts to disclose.

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Million Hearts® Executive Director Update

- **Our hearts are focused on Millions across the Nation**
- Cardiovascular Health and Prevention Remain a Priority
- Million Hearts® in Action
  - Updates and Priorities
- Discussion / Q & A- following update on HCCP

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Our world has changed since January 28, 2020

Million Hearts®

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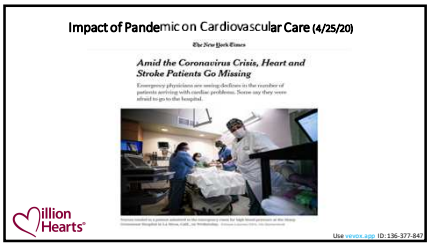
Impact of Pandemic on Cardiovascular Care (4/25/20)



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Million Hearts® Executive Director Update

- Our hearts are focused on Millions across the Nation
- **Cardiovascular Health and Prevention Remain a Priority**
- Million Hearts® in Action
  - Updates and Priorities
- Discussion / Q & A

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Current Challenges / Concerns / Gaps in Care

- 118 M Americans living with Hypertension
- Disruption of Ambulatory care
- Need for Medication Access and Adherence
- Impact on lifestyle implementation
- Disruption of cardiac rehabilitation

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

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Impact of Pandemic (MMWR)

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

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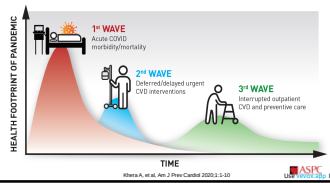
Implications of Delay and Disruption of Care During the Pandemic



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

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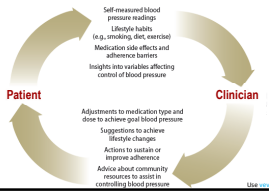
Recommendations for Patient Visits During Pandemic

- Don't defer patient visits
- Use telehealth including telephone – if at all possible
- At each visit:
  - Ask about symptoms
  - Encourage EMS/ER for concerning symptoms
  - Remind them that it is safe
  - Ensure adequate medication refills and access
  - Inquire about physical activity and nutrition habits
  - Use the full care team to enhance patient care

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

24

SMBP- Vital Signs Vital for Telemedicine



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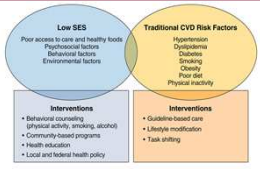
Socioeconomic Status and Cardiovascular Outcomes: Challenges & Interventions



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

26

"In the midst of difficulty lies opportunity …"

Albert Einstein

27

Optimizing Opportunities

- Acceleration of New Care Models
  - Telehealth / telemedicine
- Decreased use of low-value care
- Volume to value transformation
- Healthcare integration / consolidation

Poppas A, et al, JACC 2020; 75(3):2989-2991
Khera A, et al, Am J Prev Cardiol 2020;1:1-10

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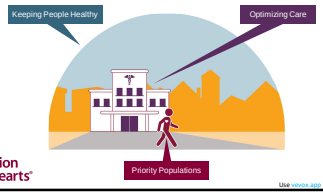
Million Hearts® 2022 Aim:
Prevent a Million Heart Attacks and Strokes in Five Years



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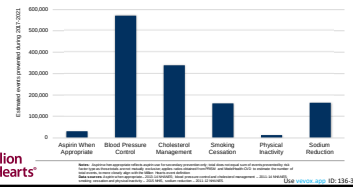
Relative Event Contributions to "the Million"



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Million Hearts® Executive Director Update

- Our hearts are focused on Millions across the Nation
- Cardiovascular Health and Prevention Remain a Priority
- **Million Hearts® in Action**
  - **Updates and Priorities**
- Discussion / Q & A- following update on HCCP

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Million Hearts® Hospitals & Health Systems Recognition Program

- A new program to recognize institutions working to improve the cardiovascular health of the population & communities they serve by:
  1. Keeping People Healthy
  2. Optimizing Care
  3. Improving Outcomes for Priority Populations
  4. Innovating for Health
- Applicants apply online by **July 31, 2020** for the second quarter.
- Million Hearts® will publicly recognize top-performing Million Hearts® Hospitals and Health Systems
- **Apply today** at https://millionhearts.hhs.gov/partners-progress/hospitals-health-systems/index.html

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MH® Updates

- CDC-F Campaign (PSA's & beyond)
- Million Hearts 1.0 Addendum ($5.6 B savings; 135K events)
- Hypertension Control Champions (118; 15M / 5 M)
- Cardiac Rehabilitation Think Tank
- AMA/ AHA Scientific Statement SMBP
- AMA validatebp.org
- JCRP & JAMA Cardiology invited commentaries
- CMS promotes V-BID in Final Payment Notice for 2021
- Reinvigorating 100 Congregations
- Updated Hypertension Control Change Package

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MH® Priorities

- Strategic Planning given current realities – Impact Document /
- Hypertension Control / Priority Populations (SG CTA / Hypertension Roundtable)
- National Association of Community Health Centers Hypertension Control / Cholesterol Management- statin videos (1400 / 24 M)
- Initiative focused on Nursing Partnerships (ORISE fellow)
- Increase uptake and implementation of evidence-based strategies
- Enhance existing internal/external relationships and partnerships (Maintain strong partnership with CMS & CMMI) ****Growth of new partnerships

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Flu and Cardiovascular Disease

- Studies have shown that flu is associated with an increase of heart attacks and stroke.
- Flu vaccination is an AHA/ACC Class 1B Recommendation for Secondary Prevention for patients with cardiovascular disease
- Flu vaccinations have shown to prevent heart attacks by 15% to 45% (a similar relative risk reduction as other guideline-directed medical therapy)

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Influenza (Flu) Burden and Vaccination

- Only 45% of adult Americans received flu vaccine during the 2018-2019 flu season
- There is a significant association between clinician recommendation and vaccination

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

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

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Summary
Million Hearts® 2022 - Executive Director Update

- Heart disease and stroke remain leading causes of death in U.S.
- Cardiovascular Health and Prevention Must Remain a Priority
- Never a more important time to focus on Millions across the nation
- Commitment to collaboration, partnership, and perseverance

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Million Hearts® Resources

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

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A Million Thanks!

More on Million Hearts at Millionhearts.hhs.gov
Reach me at LSperling@cdc.gov
Twitter @MillionHeartsUS

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Million Hearts® Hypertension Control Change Package

Lauren E. Owens, MPH
IHRC, Inc. Public Health Analyst
Million Hearts®
Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention

September 1, 2020

Million Hearts®

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- Disclaimer:

The opinions expressed by the speaker do not necessarily reflect the opinions of the US Department of Health and Human Services, the Public Health Service, the Centers for Disease Control and Prevention, or the Center for Medicare and Medicaid Services.

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Million Hearts® 2022 Priorities

Keeping People Healthy	Optimizing Care
Reduce Sodium Intake	Improve ABCS*
Decrease Tobacco Use	Increase Use of Cardiac Rehab
Increase Physical Activity	Engage Patients in Heart-healthy Behaviors

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

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

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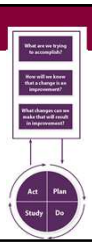
The Model for Improvement



← Quality improvement goal(s)

← SMART objective(s)

← ???

←Plan-Do-Study-Act (PDSA) cycles – AKA "rapid tests of change"

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Hypertension Control Change Package (HCCP) 2nd Edition, 2020

Access the Change Package at: https://millionhearts.hhs.gov/tools-protocols/action-guides/htn-change-package/index.html

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HCCP 2020

- Includes 253 tools from 87 organizations
- Capitalizes on 7 years of MH Hypertension Control Champions
- Features more self-measured blood pressure monitoring (SMBP) resources
- Explores potentially undiagnosed hypertension
- Added new strategies that focus on chronic kidney disease (CKD) testing and identification
- Provides more patient supports for lifestyle modifications

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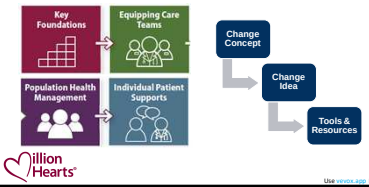
HCCP Format



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Use Practice Data to Drive Improvement

Change Concept

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Use Practice Data to Drive Improvement

Change Concept

Change Ideas

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

48

Use Practice Data to Drive Improvement

Change Concept

Change Ideas

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

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Appendices – Additional Tools

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

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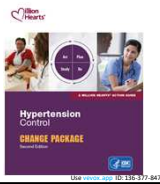
What Can Public Health Do?

- Share the HCCP with clinical partners; incorporate into QI collaboratives
- Support optimization of HTN management into health care practice
- Share HTN messages on your social media profiles → #MillionHeartsQI
- Speak with partners about how they can do the same



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Q&A

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Division for Heart Disease and Stroke Prevention, CDC

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South Carolina Hypertension Initiatives and Resources

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

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SOUTH CAROLINA PRIMARY HEALTH CARE ASSOCIATION

Access to Quality Health Care for all of South Carolina

South Carolina Primary Health Care Association

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

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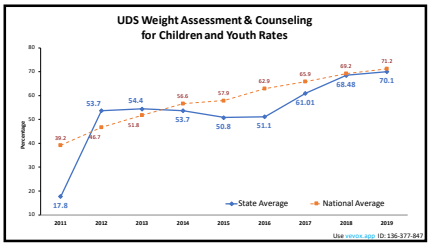

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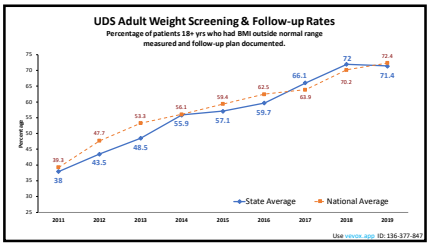

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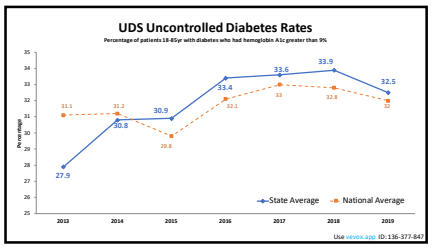

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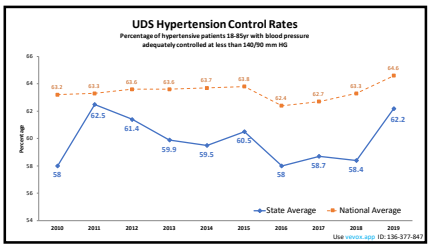

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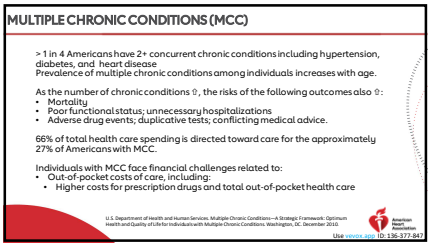

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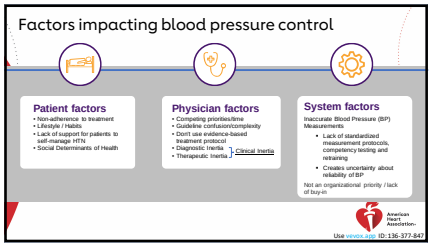

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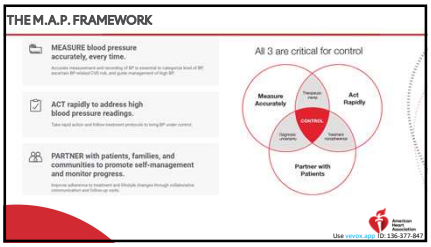

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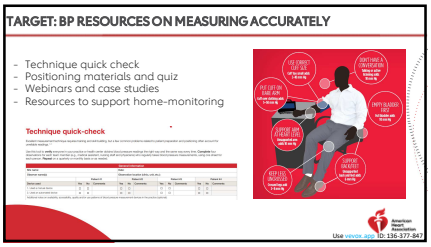

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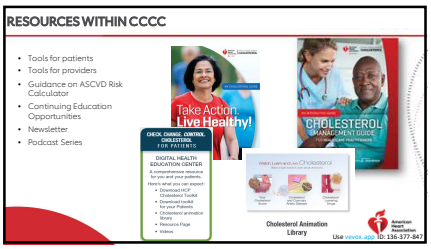

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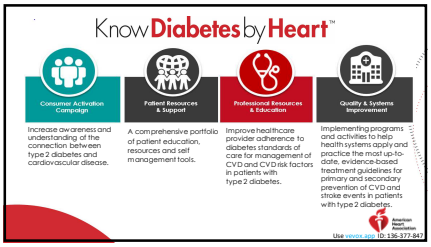

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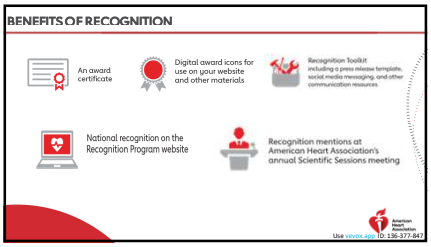

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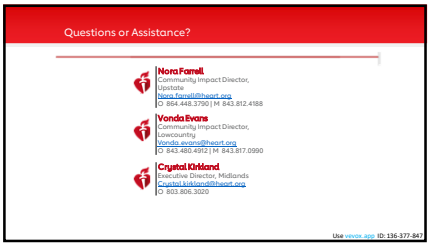

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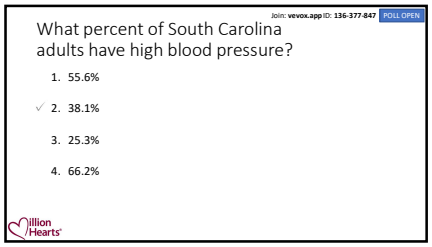

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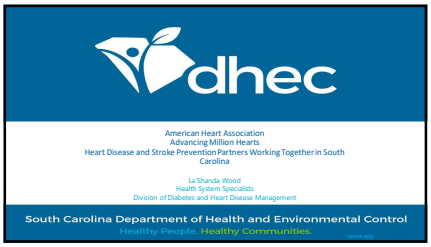

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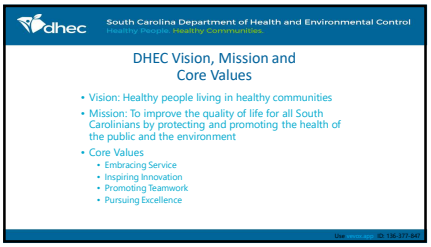

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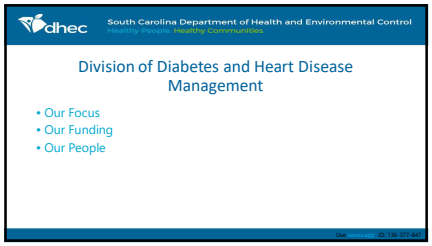

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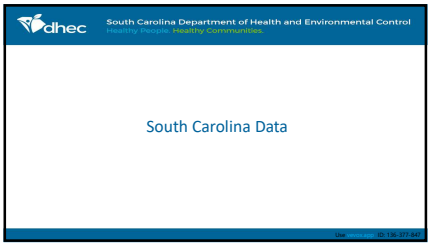

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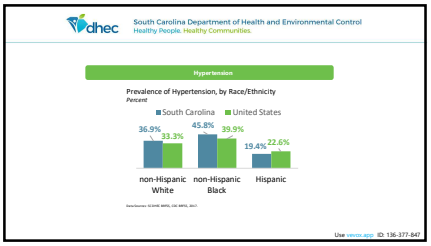

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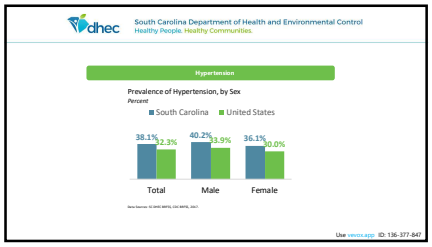

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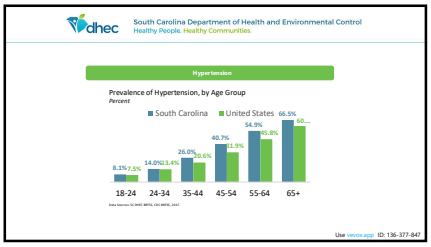

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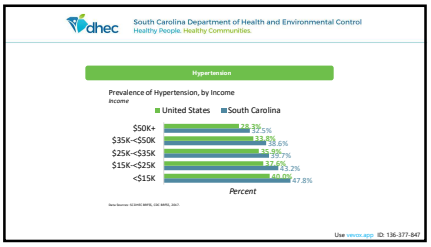

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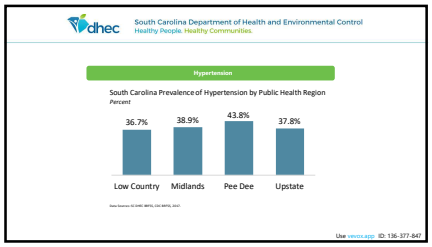

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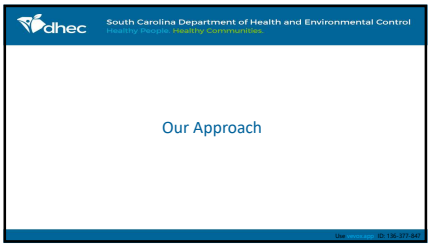

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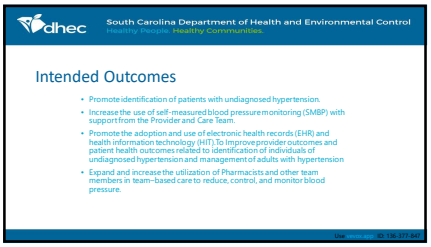

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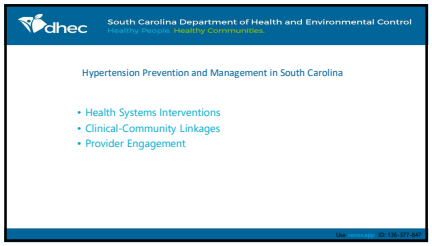

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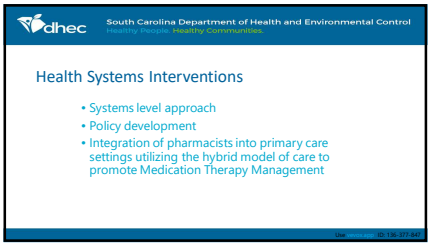

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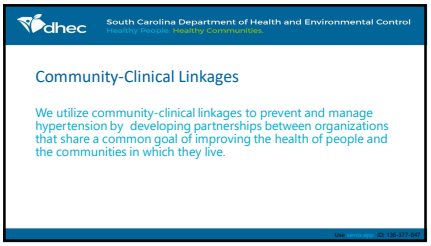

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South Carolina Department of Health and Environmental Control
Healthy People. Healthy Communities.

Provider Engagement

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

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

Collaborative Partners

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

Partners in Hypertension Prevention and Management

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

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

CONTACT US

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Q&A

Combined

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

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Stretch Break

2:00 mins

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

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

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Disclosures

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

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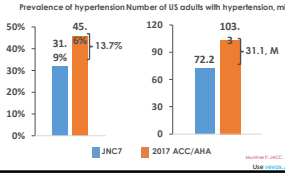
IMPACT: PREVALENCE OF HYPERTENSION – 2017 ACC/AHA AND JNC7 GUIDELINES



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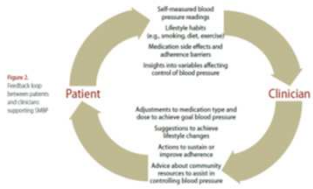
Use out-of-office BP measurements to confirm the diagnosis of hypertension and to titrate antihypertensive medication in conjunction with telehealth counseling or clinical interventions.

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

100



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

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Home Blood Pressure Monitoring

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

Hypertension. 2019;73:e35–e66.

102

Patient training provided by healthcare staff or providers

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

Hypertension. 2019;73:e35–e66

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Preferred devices and cuffs

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

Hypertension. 2019;73:e35–e66

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Best practices for the patient preparation

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

Hypertension. 2019;73:e35–e66

105

Actions to Prepare Care Teams to Support SMBP

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

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

106

Actions to Prepare Care Teams to Support SMBP

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

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

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Actions to Empower Patients to Use SMBP

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

Patients should communicate all BP records to a clinician.

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

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Home Blood Pressure Monitors

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

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

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

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

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

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

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

Hypertension. 2019;74:229-236

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Conclusions

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

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Q&A

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

Million Hearts®

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Collaborating with Community Partners to Address Patients Social and Economic Needs

TRICIA RICHARDSON
CEO
SC Thrive

Million Hearts®

113

scThrive

Collaborating to Address SDoH

September 1, 2020

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We Have the Resources

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

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The Vision: Dedicated Partners for Community Health

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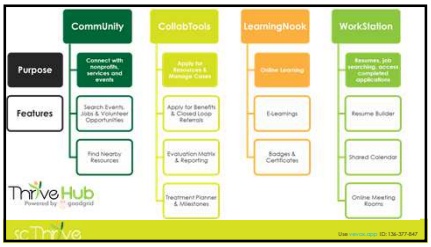

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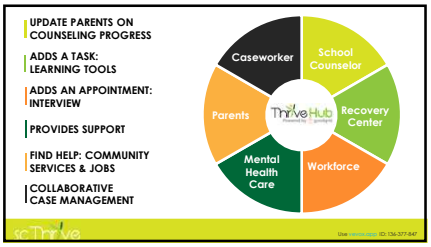

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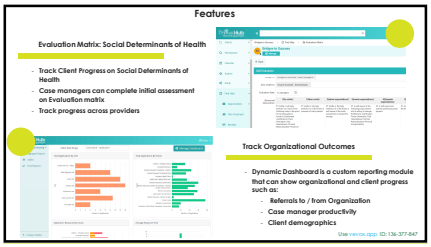

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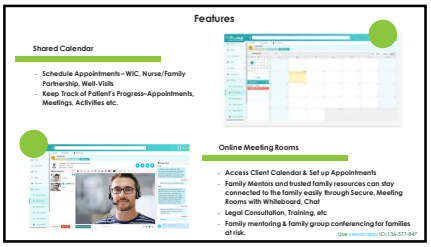

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Sandhills Medical Foundation, Inc

Improving Hypertension Control

Maximizing patient visits to support hypertension management

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

127

The Measure

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

128

SMF 2011-2014 Data

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

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IMPACT

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Quality Improvement

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

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Managing Barriers

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

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Methods

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

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Methods

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

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Change

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SMF 2015–2019 Data

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

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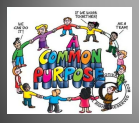
TEAMWORK



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

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Best Practice Ideas

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

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IMPACT

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

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Questions? Submit on Vevox for Q&A

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Maximizing Patient Visits to Support Hypertension Management

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

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

142

Optimizing Patient Visits to Support Hypertension Management

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

143

Our Metrics

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

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Awareness

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

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

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

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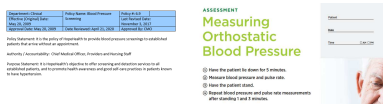
Staff Education

Refresher training on Standing Orders with regards to Hypertension/CVD

Standardization of Measuring Orthostatic BP – CDC Guideline



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Staff Education

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

147

Program Creation/Enhancements

Implemented programs that focus on identifying causes of increased BP

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

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

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

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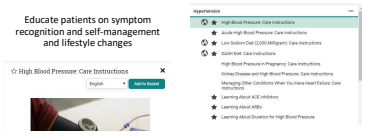
Patient Education

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



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Impact of Interventions

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

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Q&A

Combined

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

Edward Behling, MD, FAAFP
Chief Medical Officer

Tammy Garris
Clinical Data Integrity Controller
HopeHealth

Million Hearts®

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Integrating Community Health Workers into Team-based Care

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

Million Hearts®

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CENTER FOR COMMUNITY HEALTH ALIGNMENT

Integrating Community Health Workers into Team-based Care

PRESENTED BY: Andrea Heyward, MHS, MCHES

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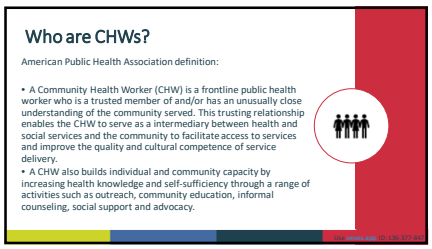

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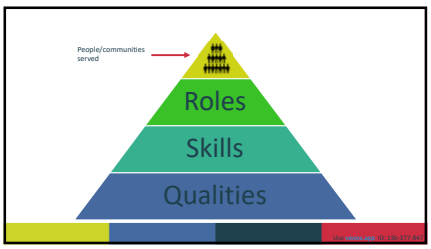

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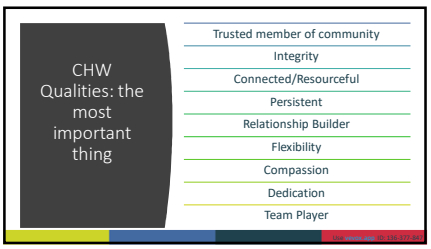

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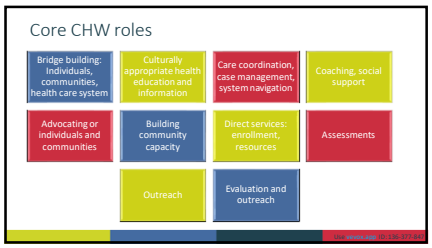

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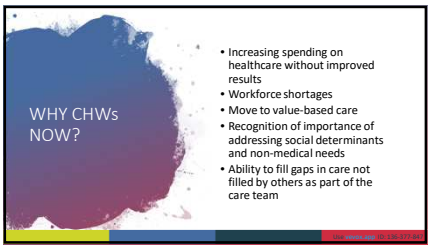

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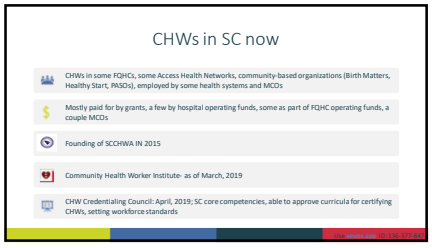

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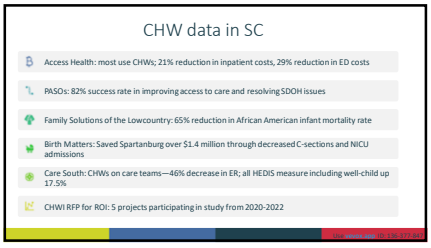

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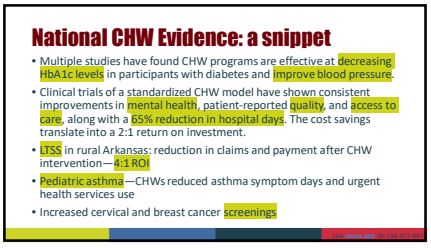

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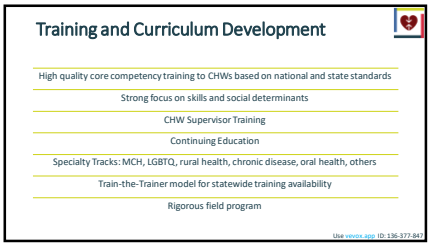

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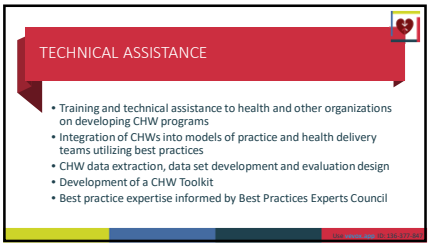

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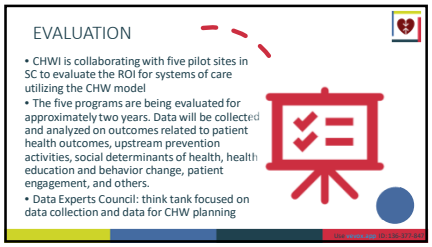

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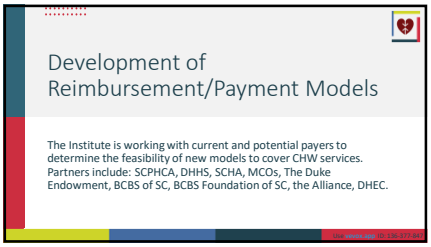

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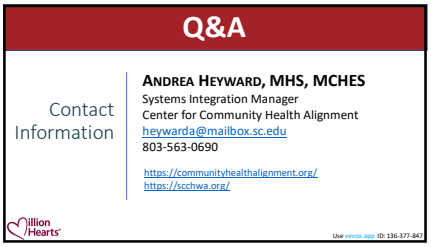

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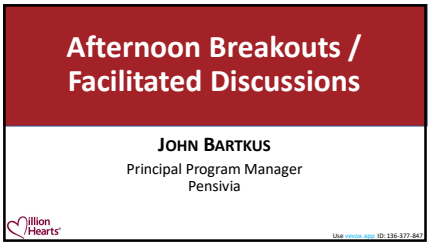

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Breakout Workgroups

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

1:55pm | 2:05pm ET

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

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Workgroup Objectives

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

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

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

Individual Take-aways: (~5 mins)

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

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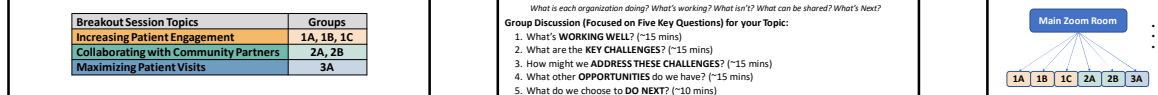
Workgroup Mechanics



- You've been **pre-assigned** to a session based on your topic choice.
- In a few moments – you'll see a **popup to Join** your session.
- At the end of the session, you'll **automatically return** to the main room. (No need to do anything)

1:55pm | 2:05pm ET

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

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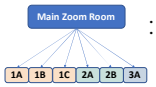
Breakouts In Progress



- If you're seeing this slide, it means you're still in the main room.
- Let John Bartkus know if you want to join one of the breakout sessions.

1:55pm | 2:05pm ET

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

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Group Report Outs

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

Order of Report outs…

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

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

Million Hearts®

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Common Strategies and Themes

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

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Next Steps

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

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Adjourn

JOHN CLYMER

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Advancing Million Hearts® - South Carolina - Partner Profiles

Summary of 21 Responding Organizations

What tools, resources or best practices do you use?

Organization Name	Team-based care	Self-measured blood pressure monitoring	Collaborative practice agreements with pharmacists	Self-management support and education	Clinical decision support systems	Community health workers	Medication therapy management by pharmacists	In-house pharmacists providing patient education services	Other (please specify)
American Heart Association		✓							
Beaufort Jasper Hampton Comprehensive Health Services	✓	✓			✓			✓	
CareSouth Carolina	✓	✓		✓	✓	✓	✓	✓	
Center for Community Health Alignment						✓			Provide TA in the areas of CHW model utilization (training & integration) and improvement of equitable practices in settings that impact community health
Centers for Disease Control and Prevention	✓	✓	✓	✓	✓	✓	✓		
HopeHealth, Inc	✓	✓	✓	✓	✓		✓	✓	Programs: HeartWise, Better Choices Better Health, Tobacco Cessation Program, SNAP into Health, Healthy Cooking classes, Seniors at Hope
Little River Medical Center	✓	✓	✓	✓	✓	✓	✓		
Medical University of South Carolina	✓	✓	✓	✓		✓	✓		Accurate BP measurement
National Association of Chronic Disease Directors	✓	✓	✓	✓	✓	✓	✓	✓	
National Forum for Heart Disease and Stroke Prevention									We advocate for all of the above and provide tools.
New Horizon Family Health Services	✓					✓	✓	✓	
Rural Health Services	✓	✓		✓	✓		✓	✓	
Sandhills Medical Foundation, Inc.	✓	✓		✓					
SC Thrive									Online application completion tool to help clients apply for Medicaid, SNAP, Prime, Long-Term Care, Welvista all online
Select Health of South Carolina	✓	✓		✓		✓	✓	✓	Provider, Member Outreach, Training, Education & Incentives
South Carolina Community Health Workers Association						✓			
South Carolina Primary Health Care Association	✓	✓		✓		✓	✓	✓	We support all of those listed
St. James Health & Wellness, Inc.	✓	✓		✓		✓	✓	✓	
Tandem Health	✓			✓	✓	✓	✓	✓	
The Carolinas Center for Medical Excellence			✓				✓		
The Consortium for Southeast Healthcare Quality									We are a consulting firm not a practice or CIN

Degree to which you have found the following to be barriers to implementing the tools, resources, and strategies

Barriers to Implementation	Organizational Survey Responses (x18 anonymous)																		Avg
Funding	4	4	5	4	3	4	5	3	2	2	5	3	3	5	5	4	3	4	3.8
Patient engagement	4	3	3	2	4	3	2	3	2	4	3	3	1	4	5	4	4	3	3.2
Staffing capacity	4	2	3	4	1	4	3	3	1	4	4	1	3	4	4	3	4		3.1
Physician engagement	3	2	3	2	2	1	3	3	1	1	3	3	2	2	2	3	5	3	2.4
Lack of management support	5	2	3	1	1	1	4	3	1	1	2	1	3	2	3	2	3		2.2

(1= not a barrier 5= inhibitor):

Source: Pre-meeting questionnaire. Respondent(s): Michele Guscio

American Heart Association

Non-profit

Which of the following resources or best practices do you use?

- Team-based care
- ✓ **Self-measured blood pressure monitoring**
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists
- In-house pharmacists providing patient education services

What successes resulted from the use of the tools, resources and strategies identified (above)?

We are not the direct providers of patient care but we do provide training and resources to healthcare providers.

Are there any strategies or activities for which you are seeking additional support or resources?

We are not seeking additional support, however, the American Heart Association has materials and resources that can be accessed on our website at https://www.heart.org/en/health-topics/high-blood-pressure.

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

We currently work with multiple community resources and would welcome the opportunity to work with new partners.

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

How has COVID-19 changed your approach to patient engagement?

COVID 19 has changed everything. The expansion of telemedicine has changed the way patients are interacting with providers.

Source: Pre-meeting questionnaire. Respondent(s): Vonda Evans

Beaufort Jasper Hampton Comprehensive Health Services

Federally Qualified Health Center (FQHC)

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- Collaborative practice agreements with pharmacists
- Self-management support and education
- ✓ **Clinical decision support systems**
- Community health workers
- Medication therapy management by pharmacists
- ✓ **In-house pharmacists providing patient education services**

What successes resulted from the use of the tools, resources and strategies identified (above)?

We have seen better adherence to treatment plans when patients more fully understand the "why" behind provider recommendations

Are there any strategies or activities for which you are seeking additional support or resources?

Encouraging patients to increase daily steps, movement, exercise.

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

Our area is severely lacking in local resources

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

Anyone who can and will help

How has COVID-19 changed your approach to patient engagement?

We have increased our telehealth services tremendously. With that being said, many of our patients lack the technology needed to fully benefit from telehealth offerings.

Source: Pre-meeting questionnaire. Respondent(s): Michele Guscio

CareSouth Carolina

Federally Qualified Health Center (FQHC)

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- Collaborative practice agreements with pharmacists
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**
- ✓ **In-house pharmacists providing patient education services**

What successes resulted from the use of the tools, resources and strategies identified (above)?

Better health choices made, medications stopped or started based on consultations, resources made available to patients. Patients are encouraged to set self-management goals which helps them decide which areas they would like to work on. By working with community health workers, patients are able to be better followed up on when they are unable to be reached by the provider for follow up.

Are there any strategies or activities for which you are seeking additional support or resources?

Transportation in rural communities, financial support to help patient with meds, dental procedures, and eye care.

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

CareSouth has a lot of different departments that offer resources. DSS, United Way, Welvista, Pee Dee Community Action Agency. CareFirst Foundation, DSS

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

Dental offices in rural communities, Walmart for food or shopping vouchers for people in desperate need, pharmaceutical companies offering discounts or no copays for meds for chronic health problems.

How has COVID-19 changed your approach to patient engagement?

We have started using telehealth visits more to reach patients who don't feel safe coming into the office.

Source: Pre-meeting questionnaire. Respondent(s): Carolyn Fulmore

Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- ✓ **Community health workers**
- Medication therapy management by pharmacists
- In-house pharmacists providing patient education services
- ✓ **Provide technical assistance in the areas of CHW model utilzation (training and integration) and improvement of equitable practices in settings that impact community health**

What successes resulted from the use of the tools, resources and strategies identified (above)?

Patient engagement, reduction in health inequities to include improved access to care. In class facilitated education provided for 20+ CHWs Initiation of a CHW weekly learning collaborative in response to the COVID-19 Pandemic Sharing and implementation of best practices related to the utilization of the CHW model across the state of South Carolina. Training of CHWs Adoption and improvement of CHW Model in various settings Identification of CHW specific job applications at state/educational institutions

Are there any strategies or activities for which you are seeking additional support or resources?

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

Several local and statewide partnerships with healthcare systems and CBOs

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

How has COVID-19 changed your approach to patient engagement?

Source: Pre-meeting questionnaire. Respondent(s): Dom Francis

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- ✓ **Collaborative practice agreements with pharmacists**
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**

In-house pharmacists providing patient education services

What successes resulted from the use of the tools, resources and strategies identified (above)?

Are there any strategies or activities for which you are seeking additional support or resources?

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

How has COVID-19 changed your approach to patient engagement?

Source: Pre-meeting questionnaire. Respondent(s): Laurence Sperling, M.D., FACC, FACP, FAHA, FASPC

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- ✓ **Collaborative practice agreements with pharmacists**
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- Community health workers
- ✓ **Medication therapy management by pharmacists**
- ✓ **In-house pharmacists providing patient education services**
- ✓ **Programs such as HeartWise, Better Choices Better Health, Tobacco Cessation Program, SNAP into Health, Healthy Cooking classes, Seniors at Hope**

What successes resulted from the use of the tools, resources and strategies identified (above)?

Patients have been engaging in classes and taking every opportunity to learn about better food choices to control their health. We have also offered Senior and Veteran care programs for patients to become more educated and engaged in their health.

Are there any strategies or activities for which you are seeking additional support or resources?

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

How has COVID-19 changed your approach to patient engagement?

COVID-19 pushed us to fully launch portals, kiosks, the Healow app and telehealth visits/software to engage our patients in their care. We continue to see an increase in patients willing to use these services.

Source: Pre-meeting questionnaire. Respondent(s): Edward M Behling, MD, FAAFP

Little River Medical Center

Federally Qualified Health Center (FQHC)

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- ✓ **Collaborative practice agreements with pharmacists**
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**

In-house pharmacists providing patient education services

What successes resulted from the use of the tools, resources and strategies identified (above)?

Are there any strategies or activities for which you are seeking additional support or resources?

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

How has COVID-19 changed your approach to patient engagement?

Increased use of televisits

Source: Pre-meeting questionnaire. Respondent(s): D. M. Kass, M.D.

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- ✓ **Collaborative practice agreements with pharmacists**
- ✓ **Self-management support and education**
- Clinical decision support systems
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**
- In-house pharmacists providing patient education services
- ✓ **Accurate BP measurement**

What successes resulted from the use of the tools, resources and strategies identified (above)?

Improved BP control through team approach

Are there any strategies or activities for which you are seeking additional support or resources?

Home BP monitoring and out of office BP measurement

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

AHA, AHEC, DHEC and ASH Chapter

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

CMS

How has COVID-19 changed your approach to patient engagement?

lower priority for BP

Source: Pre-meeting questionnaire. Respondent(s): Daniel T. Lackland

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- ✓ **Collaborative practice agreements with pharmacists**
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**
- ✓ **In-house pharmacists providing patient education services**

What successes resulted from the use of the tools, resources and strategies identified (above)?

NACCD remains committed to cardiovascular health initiatives through Million Hearts® efforts and projects supporting pharmacy initiatives, SMBP, and CHWs. It supports public health professionals to keep up to date on the latest science and best practices through its Cardiovascular Health (CVH) Council, Issue Briefs, Fireside chats and "Off the Cuff" newsletter. Additionally, it continues to work with states on efforts to advance pharmacy-related initiatives through learning collaboratives that focus on the pharmacists patient care process and MTM.

Are there any strategies or activities for which you are seeking additional support or resources?

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

How has COVID-19 changed your approach to patient engagement?

Source: Pre-meeting questionnaire. Respondent(s): Julia Schneider

Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists
- In-house pharmacists providing patient education services
- ✓ **We advocate for all of the above and provide tools.**

What successes resulted from the use of the tools, resources and strategies identified (above)?

The National Forum produced three Shared Decision Making Guides for use by patients and practitioners to improve care and outcomes, for use in diagnosing and discussing treatment plans for FH and ASCVD and to discuss symptoms of statin intolerance.

Are there any strategies or activities for which you are seeking additional support or resources?

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

The National Forum for Heart Disease & Stroke Prevention brings together the most dynamic and diverse organizations in cardiovascular health to: Share successful strategies and practices, and lessons learned Discuss new ideas in a collaborative environment Develop, pilot and scale innovative approaches to prevent cardiovascular disease Members value the opportunities created by the National Forum for them to engage in discussions that are uniquely inclusive, transparent and consensus-building. National Forum initiatives enable members to work together, across sectors, to develop and advance strategies to prevent heart disease and stroke in all populations. The National Forum's Annual Meeting convenes 100 thought leaders from over 60 public, private and nonprofit organizations including our members and partners. During this time, our Annual Business Meeting of the organization is held where the National Forum Awards are presented. All Advancing Million Hearts participants are invited to register to attend our virtual annual meeting on October 15, 2020. Visit www.nationalforum.org

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

NA

How has COVID-19 changed your approach to patient engagement?

Source: Pre-meeting questionnaire. Respondent(s): Julie Harvill

New Horizon Family Health Services

Federally Qualified Health Center (FQHC)

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**
- ✓ **In-house pharmacists providing patient education services**

What successes resulted from the use of the tools, resources and strategies identified (above)?

Are there any strategies or activities for which you are seeking additional support or resources?

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

How has COVID-19 changed your approach to patient engagement?

Source: Pre-meeting questionnaire. Respondent(s): Morganne Shook

Rural Health Services

Federally Qualified Health Center (FQHC)

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- Collaborative practice agreements with pharmacists
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- Community health workers
- ✓ **Medication therapy management by pharmacists**
- ✓ **In-house pharmacists providing patient education services**

What successes resulted from the use of the tools, resources and strategies identified (above)?

We have successfully increased our medication adherence for our HTN patients. This has increased the number of HTN patients with readings within the normal limits.

Are there any strategies or activities for which you are seeking additional support or resources?

We would like to be able to provide no cost medical equipment (BP cuffs, stethoscopes etc.). We would like to also learn new ways to better incorporate self-management and self-care with our patients.

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

We utilize several local organizations for resources.

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

Any resource or organization that is able to assist patients who are non-insured and under served.

How has COVID-19 changed your approach to patient engagement?

Our patient engagement has become more telephone based versus face-to-face. This has been a barrier due to lack of accessibility to the patient due to wrong numbers, unable to reach, etc. and difficulty providing education as a lot of our patients are visual learners.

Source: Pre-meeting questionnaire. Respondent(s): Angela McCall

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- Collaborative practice agreements with pharmacists
- ✓ **Self-management support and education**
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists
- In-house pharmacists providing patient education services

What successes resulted from the use of the tools, resources and strategies identified (above)?

Increasing at goal rates

Are there any strategies or activities for which you are seeking additional support or resources?

working with SCPHCA

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

SCPHCA

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

How has COVID-19 changed your approach to patient engagement?

We have less in office nurse blood pressure checks

Source: Pre-meeting questionnaire. Respondent(s): Crystal A. Maxwell, MD, MBA, FAAFP

SC Thrive

Non-profit

Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists
- In-house pharmacists providing patient education services
- ✓ **Online application completion tool to help clients apply for Medicaid, SNAP, Prime, Long-Term Care, Welvista all online.**

What successes resulted from the use of the tools, resources and strategies identified (above)?

From January 1, 2010 - December 31, 2019, the estimated value returned to South Carolina using our online application completion tool was $670 million. We have an organized system where clients can apply for government resources, submit their taxes for free and view various online trainings.

Are there any strategies or activities for which you are seeking additional support or resources?

Workforce development tied into our system; connecting to social determinants of health

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

Direct service organizations, FQHCs, food banks, nonprofits

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

Hospitals, schools, small businesses

How has COVID-19 changed your approach to patient engagement?

Most of our clients go to our partner sites around the state to get help applying for government resources utilizing our online application completion tool. Due to COVID-19 we had to ramp up our marketing efforts, pointing clients to our Contact Center because almost all of our partner sites closed. We have also had to move all our in-person trainings, such as financial health, self-care, and Mental Health First Aid, to our online learning management system.

Source: Pre-meeting questionnaire. Respondent(s): Tricia Richardson

Select Health of South Carolina

Medicaid Managed Care Organization

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- Collaborative practice agreements with pharmacists
- ✓ **Self-management support and education**
- Clinical decision support systems
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**
- ✓ **In-house pharmacists providing patient education services**
- ✓ **Provider, Member Outreach, Training, Education & Incentives**

What successes resulted from the use of the tools, resources and strategies identified (above)?

Increased compliance by Members (Medicaid Beneficiaries). we used a team based approach involving quality staff, care managers, physicians, community workers and pharmacists to assist our members in meeting their physical, behavioral and social needs. Better management of health conditions, decreased hospital readmission rates. We teach our members to manage their own health care

Are there any strategies or activities for which you are seeking additional support or resources?

We are interested in collaborating with community partners.

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

All Providers (FQHCs included) State Agencies (SCDHHS, SCDSS, SCDHEC, etc.) Various community/local, regional and state resources (varies by community/location) aunt bertha.com 211

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

We are open to collaborating with any/all interested parties to positively influence member (patient) health status.

How has COVID-19 changed your approach to patient engagement?

We are aligning our work/resources to be complimentary and supportive of the Provider's/Member's new needs and challenges. All of the staff are doing telephonic outreach. We continue to focus on social determinants of health and getting them the resources they need as well as education on physical and behavioral health needs.

Source: Pre-meeting questionnaire. Respondent(s): Nathaniel Patterson

South Carolina Community Health Workers Association

Non-profit

Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- ✓ **Community health workers**
- Medication therapy management by pharmacists
- In-house pharmacists providing patient education services

What successes resulted from the use of the tools, resources and strategies identified (above)?

Increased information on health options

Are there any strategies or activities for which you are seeking additional support or resources?

Health promotion should be emphasized

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

Dianne Call providing fresh fruits and vegetables

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

Health coaching

How has COVID-19 changed your approach to patient engagement?

Now virtual

Source: Pre-meeting questionnaire. Respondent(s): Donna Mack

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- Collaborative practice agreements with pharmacists
- ✓ **Self-management support and education**
- Clinical decision support systems
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**
- ✓ **In-house pharmacists providing patient education services**
- ✓ **We support all of those listed**

What successes resulted from the use of the tools, resources and strategies identified (above)?

Moving the needle on chronic disease management

Are there any strategies or activities for which you are seeking additional support or resources?

Learning best practices from other FQHC's

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

SC Thrive

How has COVID-19 changed your approach to patient engagement?

Transitioning to a "new" normal

Source: Pre-meeting questionnaire. Respondent(s): Sarah Cockrell

St. James Health & Wellness, Inc.

Federally Qualified Health Center (FQHC)

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- Collaborative practice agreements with pharmacists
- ✓ **Self-management support and education**
- Clinical decision support systems
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**
- ✓ **In-house pharmacists providing patient education services**

What successes resulted from the use of the tools, resources and strategies identified (above)?

Patients taking better/more control of and being more educated on their own health conditions.

Are there any strategies or activities for which you are seeking additional support or resources?

Open to any new ideas

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

How has COVID-19 changed your approach to patient engagement?

Provding more telehealth.

Source: Pre-meeting questionnaire. Respondent(s): Natasha Colvin

Tandem Health

Federally Qualified Health Center (FQHC)

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**
- ✓ **In-house pharmacists providing patient education services**

What successes resulted from the use of the tools, resources and strategies identified (above)?

Are there any strategies or activities for which you are seeking additional support or resources?

- Medication Therapy Management - Transitions of Care - Medication Assistance resources

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

How has COVID-19 changed your approach to patient engagement?

Source: Pre-meeting questionnaire. Respondent(s): Mary Francis

Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- ✓ **Collaborative practice agreements with pharmacists**
- Self-management support and education
- Clinical decision support systems
- Community health workers
- ✓ **Medication therapy management by pharmacists**
- In-house pharmacists providing patient education services

What successes resulted from the use of the tools, resources and strategies identified (above)?

As the SC QIO, we provide education and technical assistance to providers on chronic disease self-management and pharmacy-supported interventions. We do not work directly with patients.

Are there any strategies or activities for which you are seeking additional support or resources?

We are currently recruiting practitioners to join our QI efforts. Our goal is to provide data support and technical assistance without adding to provider's burden or duplicating efforts

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

We are implementing a population health approach to connect health care providers with community resources at the local and state level to address social determinants of health.

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

We're always looking to add more health care providers and community resources to our network to improve communication and facilitate sharing.

How has COVID-19 changed your approach to patient engagement?

The QIO program primarily works with providers and statewide stakeholders, not directly with patients; however, we support statewide patient engagement efforts and can offer assistance with virtual platforms. We are providing education on infection prevention with DHEC and sharing best practices through our newsletter and social media.

Source: Pre-meeting questionnaire. Respondent(s): Karen Southard

Which of the following resources or best practices do you use?

- Team-based care
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists
- In-house pharmacists providing patient education services
- ✓ **We are a consulting firm not a practice or CIN**

What successes resulted from the use of the tools, resources and strategies identified (above)?

We deploy many of the strategies listed in 6 in our quality improvement work with clinicians, practices, health systems

Are there any strategies or activities for which you are seeking additional support or resources?

With which community resources/organizations are you currently working to help patients meet their social and economic needs?

State Health Departments, Rural Health, individual practices

With which community resources/organizations would you like to work to help patients meet their social and economic needs?

How has COVID-19 changed your approach to patient engagement?

We don't work directly with patients

Source: Pre-meeting questionnaire. Respondent(s): Debra Simmons