Advancing Million Hearts®

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

September 25, 2019
Meeting Summary

Lod Cook Alumni Center
Louisiana State University
Baton Rouge, Louisiana

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Meeting Summary

Purpose: To develop a coordinated strategy for addressing hypertension in Louisiana.

Objectives:

1. Increase understanding of the existing hypertension initiatives implemented through various organizations.
2. Identify opportunities for alignment of existing efforts.
    - Increase healthcare provider engagement in hypertension management initiatives
    - Implement self-measured blood pressure monitoring with clinical support
    - Increase community-clinical partnerships for hypertension management
3. Identify gaps in services (populations, geographic regions, etc.)
4. Develop plans for maximizing existing efforts and addressing unmet needs.

Overview

On September 25, 2018, 55 representatives from 22 health organizations devoted to reducing the prevalence of heart disease met in Baton Rouge to advance the mission of the Million Hearts® initiative.

The partner organizations collaborated on ways to align their individual efforts to better meet the Million Hearts® goal of preventing a million heart attacks and strokes over the next five years. Representatives shared information about their organizations' hypertension management programs and resources to identify alignments, assess opportunities to expand efforts and to fill gaps in services.

Participants then separated into breakout groups to discuss and establish action plans around three priority areas:

- Identify opportunities to increase healthcare provider engagement in hypertension management initiatives.
- Identify opportunities to implement self-measured blood pressure monitoring with clinical support.
- Identify opportunities to increase community-clinical partnerships for hypertension management.

The day's discussions helped participants expand their knowledge of existing efforts and initiatives addressing hypertension, initiate opportunities for collaboration and share success and lessons learned with peers.

Approximately 20 of the 51 participants responded to the post meeting evaluation survey. Of those who responded, 44% participated in the discussion about increasing healthcare provider engagement in hypertension management initiatives; and 28% participated in each of the remaining two groups. Feedback reflected the depth and value of information yielded from discussions. Participants appreciated the opportunity to identify new partners, learn about existing efforts, obtain new tools and resources as well as network with colleagues.

Suggestions for next steps include developing a plan for maintaining momentum and continuing regular communication, establishing a regular meeting schedule every 4-6 months and increasing organizational representation on the group.

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

The follow responses were shared by meeting participants:

-Ways to make Louisiana healthier.
-More information on hypertension that I can bring back to my community.
-Improving the health of Louisiana.
-Identifying opportunities to help us all support heart disease prevention efforts.
-Aligning all our teams together.
-Learning from the partners that we already have to make sure that we collaborate and do more work here.
-Shaping the work that I do each and every day.
-Hearing from all of you and hearing what's working, what isn't working, and figuring out how to pull together.
-Stronger partnerships after today.
-Learning how we can connect the people in the capital area to let them know the resources that are available to them.
-Increase engagement with providers through our provider engagement network.
-Learn how we can collaborate on a few of our relationships.
-Build a bidirectional referral process between our clinic and the physicians' office.
-Build partnerships and to see what other agencies are doing when it comes to managing hypertension.
-Expand our community outreach to prevent heart disease and stroke and better understand the needs of our community.
-Hearing what programs are available for partnering so that we can make an impact in our communities.
-Learning about fun and innovative ways to be able to engage our community and be aware of the hypertension issues that we do have.
-Bring education to our rural community and the capital area.
-Transforming the health care system.
-Take the lessons learned from this process and help other states as well.
-Connect with other groups who can help us and produce health outcomes.
-Looking at the social determinants of health.
-Developing strategic partnerships in Louisiana and to be able to translate this beyond these four walls.
-Take back ideas on how to operationalize blood pressure control.
-Take back information to our providers and then therefore to our patients to help them live a better, healthier life.

Agenda

Time	Agenda Item/Topic	Speaker/Facilitator
8:30 – 9:00 am	**Partner Networking**	
9:00 – 9:15 am	**Welcome** **Overview of the Day**	**John Clymer** Executive Director, National Forum for Heart Disease and Stroke Prevention **Julie Harvill** Operations Manager, Million Hearts Collaboration, American Heart Association
9:10-9:30	**Introductions** In one sentence, what excites you about your role in heart disease and stroke prevention?	**John Bartkus, PMP, CPF** Principal Program Manager, Pensivia
9:30 – 9:45 am	**Million Hearts® 2022** **Q and A - Group Interaction**	**Tiffany Fell** Deputy to Associate Director Policy, External Relations, and Communications Office Division for Heart Disease and Stroke Prevention National Center for Chronic Disease Prevention and Health Promotion, CDC
9:45 – 10:00 am	**Louisiana Department of Health Hypertension Initiatives**	**Melissa R. Martin, RDN, LDN** Well-Ahead Louisiana Director
10:00 – 10:15 am	**Quality Insights, Quality Innovation Network**	**Debra Rushing** Cardiac, Louisiana State Lead
10:15-10:30 am	**American Heart Association Hypertension Initiatives**	**Ashley Hebert, MPA** Government Relations Director, Louisiana **Coretta LaGarde** VP, Health Strategies, Louisiana
10:30 – 10:45 am	**Break**	
10:45- 12:00 pm	**Louisiana Partner Hypertension Initiatives** Partnering with providers to implement sustainable systems changes **Bogalusa Heart Study and Hypertension** **Louisiana Perinatal Quality Collaborative** **Sankofa Community Development Corporation** **Rural Health Center Hypertension Programs**	 **Kenny J. Cole, MD, MHCDS** System VP, Clinical Improvement Ochsner Health System **Camilo Fernandez, MD, MSc, MBA** Senior Research Scientist Center for Lifespan Epidemiology Research Department of Epidemiology, Tulane University School of Public Health and Tropical Medicine **Veronica Gillispie-Bell, MD, FACOG** Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review **Danelle Guillory, MD, PhD** Healthy HeartBeats Program **Colleen Arceneaux, MPH** Population Health Manager, Well-Ahead Louisiana, Louisiana Department of Health / Office of Public Health
11:25 – 11:45 am	**Finding Connections and Alignments**	**John Bartkus**
12:00 pm	**Lunch**	

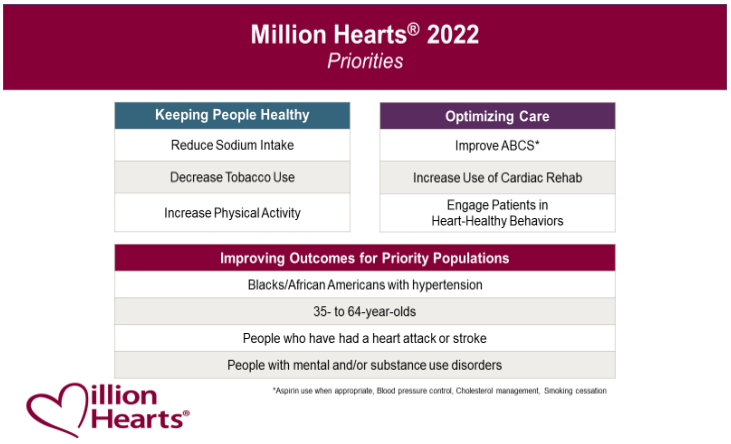
12:45 – 2:20 pm	**Afternoon Breakouts/Facilitated Discussions** • Provider engagement in hypertension management efforts • Self-measured blood pressure monitoring with clinical support • Clinical-community partnerships for hypertension management	**John Bartkus**
2:20 – 2:50 pm	**Group Report Outs and Next Steps**	**John Bartkus**
2:50 – 3:00 pm	**Evaluation and Feedback Process**	**Sharon Nelson, MPH** Program Initiatives Manager, Million Hearts Collaboration, American Heart Association
3:00 pm	**Wrap Up/ Adjourn**	

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

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



We project 279,300 "Million Hearts preventable events" that will occur in LA if we do nothing

- **6% reduction of those events = 16,800 events we hope LA will prevent**
  Resources:
  - **Action Guides**—Hypertension control; Self-measured blood pressure monitoring (SMBP); newly released Tobacco cessation; Medication adherence
  - **Protocols**—Hypertension treatment; Tobacco cessation; Cholesterol management
  - **Tools**—Hypertension prevalence estimator; ASCVD risk estimator
    - **Messages and Resources**—Undiagnosed Hypertension, Medication Adherence, Health IT, SMBP, Particle Pollution, Physical Activity, Tobacco Use
  - **Clinical Quality Measures**
  - **Consumer Resources and Tools**

  SMBP Forum
  - Join the SMBP Forum at http://bit.ly/SMBPForum
  - Access materials via the SMBP Healthcare Community
    Go to www.healthcarecommunities.org and log in to your account (free to register)
    Search for 'SMBP' under the 'Available Communities' tab
    Click "Join Community"
  - Questions: MillionHeartsSMBP@nachc.org

- NACCHO Toolkit

- Revised Hypertension Control Change Package- revised version coming in 2019!
- Hospital/Health System Recognition Program- in close collaboration with NACDD, announcement coming in October 2019!
- Million Hearts for Clinicians Microsite- Features Million Hearts® protocols, action guides, and other QI tools; Syndicates LIVE Million Hearts® on your website for your clinical audience.

Louisiana Department of Health Hypertension Initiatives

Melissa Martin
Well-Ahead Louisiana Director

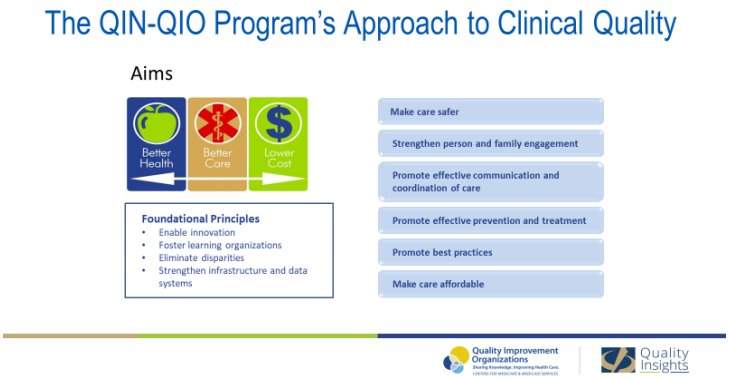
See video!

11 different programs that touch heart disease and prevention efforts

- Community resource development and Healthy Community Coaching- includes community-clinical partnerships to increase access to programs for their patients. For ex- SMBP programs in the community. Maintains a resource guide found on their website to support individuals and providers (ask Melissa for link?). Additional efforts to enhance infrastructure for CHWs.
- Wellspot Designation http://wellaheadla.com/WellSpots/Find-WellSpots - over 16 chronic disease programs such as self-assessments for health.
- SMBP Programs and Clinical Support
- Barbershop projects- Cutting the Pressure and other pilot projects. 3 barbers have been trained to do SMBP programming. Based on the outcomes, they will share lessons learned.
- Quit with US. LA- shared partner brand for the 1800 Quit Now quitline offering NRT and cessation counseling via phone, web, and soon text.
- WISEWOMAN
- WELL AHEAD http://wellaheadla.com
- Practice Coaches- working in clinical setting working with providers who are interested in these initiatives
- Population Health Cohort- focused on quality initiatives.
- Medication Adherence and Therapy Management- working with clinical pharmacy in several interventions.
- Stay connected at www.walpen.org

QIO Hypertension Initiatives

Debra Rushing
Cardiac, Louisiana State Lead



Cardiovascular Health

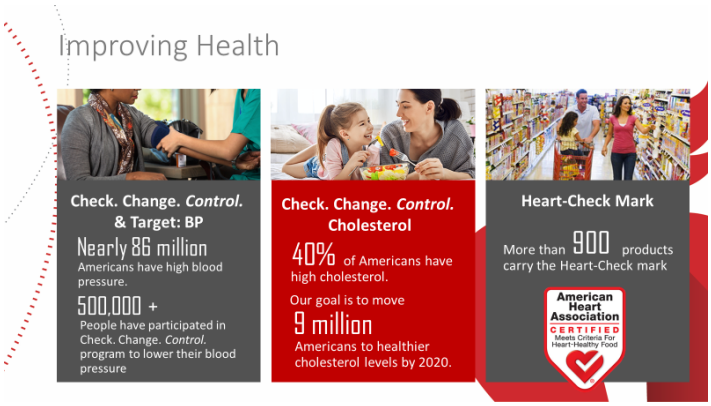
- Directives - Stroke prevention, HTN and smoking cessation
- Promoted Million Hearts website, best practices, resources
- Encouraged/increased use of BP protocols in practices and HHAs
- Promoted use of HHQI's cardiovascular data registry in home health setting
- Developed/promoted Quality Insights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

➢ Work with clinician practices on whether they have a protocol in place and they help them get one in place.
➢ Work with data registry.
➢ All the QIO work is free and you can get CEU's by being trained through various resources.

American Heart Association Hypertension Initiatives

Ashley Hebert, Government Relations Director, Louisiana
Coretta LaGarde, VP, Health Strategies, Louisiana

- Check.Change.Control
- TargetBP
- Get With the Guidelines
- HeartCheck products in grocery stores- working with New Orleans and Baton Rouge grocery strores
- A newer initiative- Know Diabetes By Heart- combat diabetes across Louisiana
- Spotlight on Louisiana- listing hospitals involved in Stroke care
- AHA Advocacy- Healthy Eating/Active Living and Tobacco Free



Online Tools

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

Resources

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

Know Diabetes By Heart

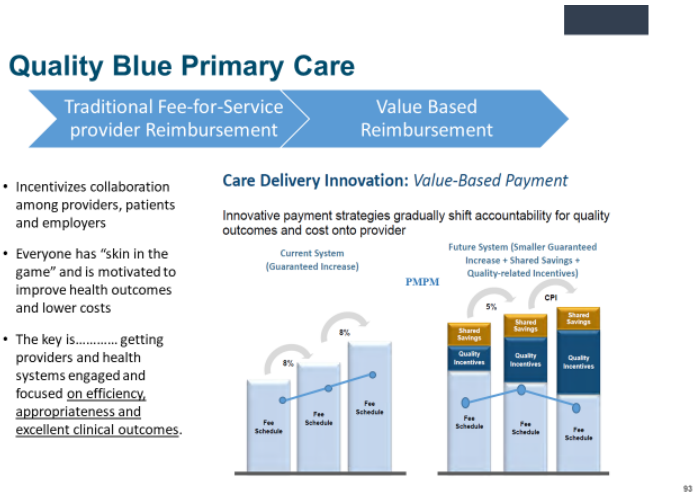
Louisiana Partner Hypertension Initiatives

Kenny Cole, Systems VP
Clinical Improvement, Ochsner Medical Center

Measure Up Pressure Down AMGA program

Evidence Based Program-

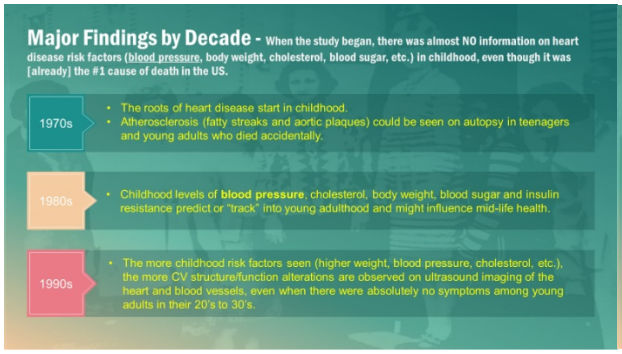
- Includes key steps in measurement, goals, ancillary testing, life style modifications, and patient engagement strategies
- Flows pathway for medication prescription and follow up visits based on how far BP is out of control
- Identifies additional tests for treatment resistant hypertension
- Lists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

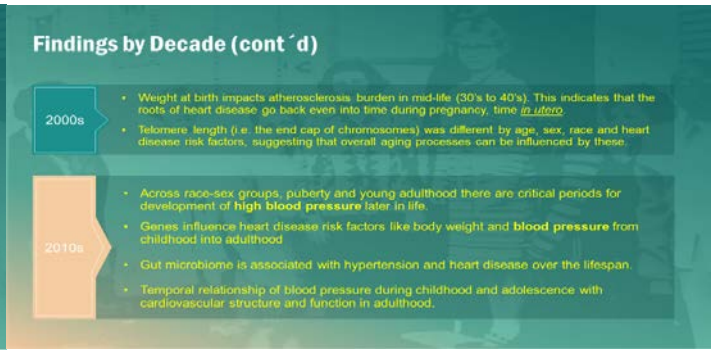


Bogalusa Heart Study and Hypertension

Camilo Fernandez Alonso
Department of Epidemiology, Center for Cardiovascular Health
Tulane University School of Public Health and Tropical Medicine
New Orleans, Louisisana

- One of the longest on-going studies of a biracial, semi-rural community in the Southern US. Our focus is on understanding the impact of cardiovascular and metabolic changes on health throughout the lifespan.
- 170+ studies/sub-studies have been conducted over the years, which include special studies on socioeconomic evaluations, blood pressure studies, a lipids study, genetic/epi-genetic studies, exercise, heart murmur studies, newborn cohort, diabetes, pathology, and CV imaging
- More than 1,000 publications, five textbooks and numerous monographs have been produced describing observations on more than 12,000 children and adults in Bogalusa, Louisiana.

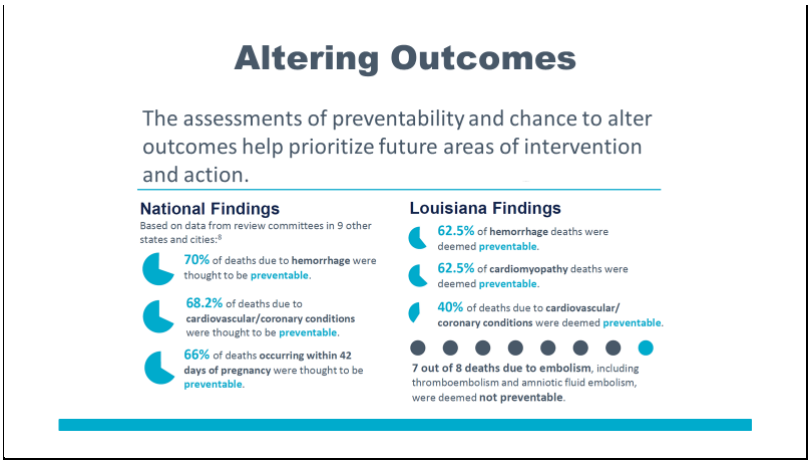




Addressing Maternal Mortality in Louisiana

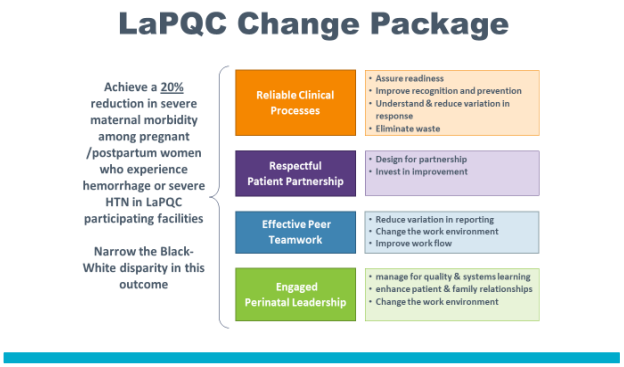
Veronica Gillispie-Bell
Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review
Obstetrics & Gynecology

Louisiana Maternal Mortality Review Report 2011-2016



What is the LaPQC?

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



<u>Sankofa Community Development Corporation</u>

Danelle Guillory, Healthy Heartbeats Program

Program Overview

Our programs shape health, influence systematic change and address the social determinants of health that trigger and sustain inequalities

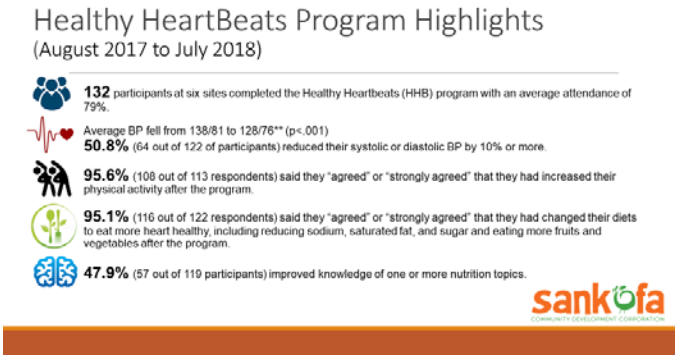
Program Goals

To create a local environment that promotes positive health outcomes & long-term community well-being

To promote personal wellness in alignment with healthy families as the cornerstone of a thriving, cohesive community, for cohesive communities

To build healthier communities for present and future generations

- Peer leadership by Community Health Ambassadors (CHA)
- CHAs trained as peer educators and provide ongoing guidance and advisement on program growth and development
- Hypertension and nutrition education using the American Heart Association EmPOWERED to Serve curriculum
- Self-monitoring blood pressure and health measurements
- Access to fresh produce
- Health care provider treatment



Breakout Group Discussions:

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

Group	Topic	Co-Facilitators	Support
1	Physician Engagement in Hypertension Management Efforts	Chelsea Moreau Latraiel Courtney	Melissa Martin Julie Harvill John Clymer
2	Self-measured Blood Pressure Monitoring	Coretta LaGarde Danielle Guillory	Katelyn King Kelly Flaherty Sharon Nelson
3	Clinical Referral to Community-based Hypertension Management Programs	Colleen Arceneaux Brian Burton	Ashley Hebert Erin Leonard Julia Schneider

The following notes were taken during each discussion.

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

Group 1: Provider Engagement in Hypertension Management Efforts

ACTIVITIES / RESOURCES

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

Describe Strategies/Approach employed to Increase Provider Engagement.

- **Team-based care**
- **Collaborative Practice Agreements with Pharmacists**
- **Clinical Decision Support Systems**

- Get with the Guidelines AHA, recognition
- Barbershop and Salon programs – AHA, Our Ladies of Angels
  - Taught how to take using digital monitors, referral mechanism back to ER, provider, etc.
  - Showing or creating the best place to measure blood pressure
  - Importance of medications
  - Posters and resources
- Reassess how blood pressure is being measured
- HTN Management – quality checks, FQHC
  - EHS – Energy
  - Providers have walk in appointments am and pm;
  - One clinic is going to try a half a day on Saturday

Describe Successes that resulted.
Describe Challenges/Barriers you've encountered.
Describe Resources you are able to share.

- How we are accessing hypertension in the first place
- AMA Target BP training – check list on proper BP measurements
- Target BP.org numerous resources
- Meds to Beds - Pharmacy in house
- Patient Assistance next works
- Translatable Resources
- Chelsea Moreau – AHA
- Initiatives – get persons in before their meds run out
- Continuing education – provider meetings
- Level sets
- Well Ahead Resource Guide – great tool, can't praise enough
  Assess our communities and see why you need to be included and heard
- Know Diabetes by Heart, can implement a Target BP time program in your clinic

ALIGNMENTS / CONNECTIONS

Where can we support each other?
What alignments and connections across our organizations do we want to pursue?

- Pharmacists – interested in self-help / engagement for their patients of chronic diseases
- Connecting pharmacy and primary care – writing collaborative practice agreements
- Medication therapy management practice agreement – Pharmacists alert physician RX did not get filled.
- Physician can run a report and follow-up.
- Insurance is now following up
- Clinical Decision Supports – EHR can do a lot for your practice, great reports by Athena
  Automated triggers, project ECHO coming to Louisiana.

Out of the University of Mexico – rural health clinic providers, NP, PC, sending their complicated diabetics to specialty based upon the payment structure, lack of knowledge and training, uses other allied health professionals to provide a virtual - similar to grand rounds when in med school, those engaged in online training, can have the cardiologist may recommend how a primary care provider can treat their patients, make those clinical decisions to not have to refer out.

- Getting to a specialty provider – patients must wait a long time –
- Tool – can expand to multiple topics

Working with patient navigators or community health workers?

What can we do next and how can we work together?

- Webinar during lunch time frame and with meals
- Training – disease process updates – CEU's – more provider engagement

What is needed – works in IT Department – case management point of view, back to their provider.

- Have you kept your appointment, what barriers do you have?
- Patient Navigator (staff)
- CQM data

NEXT STEPS (TAKING ACTION AND SUSTAINING MOMENTUM)

WHAT DO WE DO NEXT? HOW DO WE KEEP THE EFFORT MOVING AND GET RESULTS?

- Identify the resources and make sure providers get them and use them
- Provider as the speaker/trainer
- Identify opportunities to use EHR data to support hypertension control
- Elevate the value of CHW/patient navigation
- Provider and system score cards increase accountability

WORKGROUP TEAM ROSTER

Name	Organization	Email Address	Phone
Chelsea Moreau	American Heart Association		
Latraiel Courtney	Well Ahead Louisiana	Latraiel.Courtney@LA.GOV	
Melissa Martin	Well Ahead Louisiana	Melissa.R.Martin@la.gov	
Julie Harvill	American Heart Association	Julie.harvill@heart.org	

John Clymer	National Forum for Heart Disease & Stroke Prevention	John.clymer@nationalforum.org	
Stacie Bland	Baton Rouge Primary Care	sbland@brprimarycare.org	
Annie Gayden	Nightingail Healthcare Resources	jaiarleane@yahoo.com	
Jasmine Breaux	Baton Rouge Primary Care	jthrash@brprimarycare.org	
Deante Baham	Well Ahead Louisiana	deante.baham@la.gov	
Jackie Harbour	Opelousas General	jackieharbour@opelousasgeneral.com	
Wanda Smith	Nightingail Healthcare Resources	wsmithNHR@gmail.com	

Group 2: Self Measured Blood Pressure Monitoring Programs and Clinical Supports

ACTIVITIES / RESOURCES

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

Describe Strategies/Approach employed for Self-measured blood pressure monitoring with clinical support: Patient monitoring of blood pressure at home or elsewhere with clinical support including training on use of BP monitor, tracking home BP reading and guidance as needed.

- Prepare the care team to support SMBP (e.g., train staff on proper blood pressure measurement, identify staff to provide clinical support, implement standardized treatment protocols).
- Select and incorporate clinical support systems to track BP readings
- Empower patients to monitor their blood pressure (selecting the "right" monitor, taking accurate measurements, tracking measurements, providing access to monitor if needed)

Describe Successes that resulted.

1. Community Health Workers
2. Operationalizing initiatives through Cohorts instead of Individuals
3. Barbershop Initiatives
4. Champions (Community and Clinic-based)
5. Incentives
6. BP Cuff Loaner Programs

Describe Challenges/Barriers you've encountered.

1. Sustainability
2. Bandwidth to Implement (Time Overall)
3. Clinical Support and Care Team Resources
4. Blood Pressure Cuffs
5. Easy Online Access in ALL Communities

Well Ahead Louisiana – Need a champion to be present in the community is very important. They must check in and make sure everything is running smoothly and help where necessary. Vision is to work in Barber Shops and expand work to non-profit and faith-based organizations; councils on aging.

Challenge: Gaining clinical support at the beginning of the project. The community can be ready, but the clinical support side may not be. Tooling people to be best ambassadors possible. But can have all the community support, but without the clinical support, won't work.
Questions: How do we remove the barriers to clinical support and help them? Need capacity in the clinic to do education. How to get them the resources they need?

Bunkie General Rural Health Clinics - Working with pharmacists on SMBP to be the blood pressure check point. Getting machines to home health care workers, hospitals, pharmacists. Two, pharmacies, 1 church, and the Council on Aging have contributed BP cuffs.

Challenge: Getting BP cuffs to those who need them Dr. Alonso recommended getting cuffs donated by a manufacturer. SpaceLabs, SunTech; Omronare manufacturers interested in helping. Can also get newer instruments they want to test – already validated, but not enough testing conducted yet. He also suggested applying for AHA innovation grants or other funding institutions for devices.

Challenge: How to increase patient compliance with monitoring? Patients may not have access to the resources to do so – transportation, cuffs, etc.

Challenge: How to get physicians in hospitals to take the actions necessary. How do you get them the time they need to support the program?

Parish Health Units– standardizing screenings; got lots of engagement; new guidelines released same timeframe, but high reading from health units not confirmed when referred to personal physician– may have been a one-time spike, using old guidelines, or other. Empowering patients.

Utilize telemedicine (from Tulane) to train providers or others to take BP. Can contact them to get the training.

Patient education on AHA site – target BP – how to take BP, but not hands on. AHA also has blood pressure booklets to track readings. AHA resources are great; easy to understand; shows what to do; what happens with undiagnosed hypertension. Patient education materials good resource too – easy to relay messaging to the barbershops. Patients began to tell the nurses and doctors how to do it.

Challenge– not having enough bandwidth to implement. FQHC with LSU medicine partner to meet the need and meet the patients where they are. Certintell offered remote patient monitoring program.

Empower to Serve Curriculum modified to create community ambassadors that are culturally relevant. Input and feedback on what would resonate with peers. Community Health Ambassadors run a 10-month program of classes and they follow up with participants who don't come. Grant funded through AstraZeneca. Can you provide an incentive to get them to come? i.e voucher for a free haircut to come to the barbershop talk.

Other incentives that work – water bottles, key chains, competitions with barbershops who get the most screened. Could work on clinical side; who is doing the best job of promoting…bragging rights.

Healthcare in the clinics is changing. Documentation, preventative, quality of care – big challenge for the nurses in the clinics. Inundated with change clinics struggling with referrals. Referrals for Cessation – as an example; some docs follow through; some don't. Trying to do an online process through QuitLine, but patient must be willing and ready to quit. And there is a cost to it.

Stories to illustrate the cost of not adopting healthy lifestyle. Example of African American male smokers. They don't go to the doctor. Needed Non-traditional cessation practices. Positive reinforced messages. Didn't know about Quitline or free resources available. Takes time to educate them about risks, resources. Phase 2 – make the ask – to get them to quit. Trained tobacco consultants; job centers, faith-based centers, etc – non-traditional spaces.

- Prepare the care team to support SMBP (e.g., train staff on proper blood pressure measurement, identify staff to provide clinical support, implement standardized treatment protocols).
- Select and incorporate clinical support systems to track BP readings
- Empower patients to monitor their blood pressure (selecting the "right" monitor, taking accurate measurements, tracking measurements, providing access to monitor if needed)

Describe Resources you are able to share.

1. Million Hearts; AHA; AMA
2. Barbershop Toolkits (and other Toolkits)
3. Donations from Spacelabs, Omron and Suntech for cuffs
4. Tulane Telemedicine Training on SMBP (FREE) Can be done Virtually or Face to Face
5. Utilizing Community Partners such as Pharmacies, Councils on Aging, Job Centers and Faith Based Institutions

ALIGNMENTS / CONNECTIONS

Where can we support each other?
What alignments and connections across our organizations do we want to pursue?

This group develops training for Community health workers; educating about chronic diseases.
(Medicaid can provide reimbursement for but need certain certifications, etc. – large undertaking)
Identify, Train and Deploy Community Health Workers (Healthy Heart Beat Ambassadors, Practice Coaches, LaCHON)

Population health dynamics are growing in importance. Chronic care management is coming. Someone has to figure it out. Need continuity to work on it. Meet regularly to keep the ball rolling. Bigger health system groups will start coming together.

Can we tap AMA training if we have enough numbers? Rural population health cohort – programmatic umbrella through Dept of Health.

Toolkit for Louisiana on how to implement SMBP in your area.

Join the SMBP Forum that is part of Million Hearts.

Healthcarecommunities.org SMBP community within. By the National Association of Community Health Centers. Different resources for different audiences. Can be looking for models.

Promote Telemedical Initiatives
Provide Universal Training (specifically to Population Health Cohort) Please note that going forward, AMA-led practice facilitation will be available only for healthcare organizations serving over 100,000 adult patients with hypertension.

NEXT STEPS (TAKING ACTION AND SUSTAINING MOMENTUM)

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

Connect with Obesity Commission – initiate/create BP Sub-Committee or Hypertension Advisory Council
Well-Ahead to put together a Statewide toolkit with resources for training and information on how to get funding
Engage Payers | Insurers to pay for blood pressure cuffs or provide at no cost
Medicaid Reimbursement services for Community Health Workers
Touch – Communicate – Outreach

Create network for region
Determine how to pursue Medicaid reimbursement
Group should meet monthly or bi-weekly
Well ahead is putting together a list of resources
Develop initiatives and trainings
What is the sustainable infrastructure to support the work through Well ahead obesity commission? or other channels.
To Do for All: Join SMBP Forum (Million Hearts to send link) and healthcarecommunities.org for the most up-to-date info.

WORKGROUP TEAM ROSTER

Name	Organization	Email Address	Phone #
Coretta LaGarde	AHA	coretta.lagarde@heart.org	
Danelle Guillory	Sankofa	danelle@sankofanola.org	
Kaitlyn King	Well-Ahead	kaitlyn.king@la.gov	
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Marcy Hubbs	Well-Ahead	marcy.hubbs@la.gov	
Becky Wilkes	Well-Ahead	rebecca.Wilkes@la.gov	
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Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners
Working Together in Louisiana – September 25, 2019

Group 3: Clinical-Community Partnerships for Hypertension Management

ACTIVITIES / RESOURCES

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

Describe Strategies/Approach employed for Clinical-community partnerships for hypertension management: Connecting community programs with health systems to improve chronic disease prevention, care, and management.

- Working with community partners to provide self-management support and education
- Engaging Community Health Workers in the health care team
- Working with pharmacists to provide Medication Therapy Management
- Implementing referral systems and tracking patient participation in lifestyle change programs

Describe Successes that resulted.

MCO is really focused on NQF18. They have a number of quality measures that the SHD holds the MCO accountable for. If BP became more of a policy focus, it would trigger more activity.

How do we educate SNAP benefits how to cook healthy foods and how to pick out healthy foods?

Community education

- SNAP "buy this, not that"
- School-based events/gardens
- Resources

Leverage existing community partnerships
Community benefit dollars- where is the 340B dollars going; hospitals need education on where to invest these funds especially on social determinants of health. A lot of opportunity to provide input as the hospital is planning.

Tobacco cessation resources for the quitline

Describe Challenges/Barriers you've encountered.

HTN needs more of a state focus on the policy level- state accountability in contracts?

Every community in LA is so different so even though there could be an overarching healthy foods policy in the state it would be different in every community.

Challenges with referral to quitline given high cost. There should be a referral in the EHR system and there are a lot of systems and there were a lot of challenges. They do fax to quit but a lot of clinics are no longer using fax. We don't want to create a system just for cessation/quitline if there is an opportunity to unite with another initiative.

1. Community needs to know what resources are available-does the community have the resources to begin with
2. They need to be able to be able to access a physician or CHW that can refer them-linking to the resources

ALIGNMENTS / CONNECTIONS

Where can we support each other?
What alignments and connections across our organizations do we want to pursue?

- Value in hyper targeted work groups
- What is the best system to capture resources in a community.
- Local community level-Which ones work best
- LSU AG-gap analysis
- Q10-QIN coalition meetings
- Chamber of Commerce-how to push activities into the community
- Coalition lenders

How do we unite to find discretionary dollars for the programs we need rather than be given money for prescribed programs?
For ex- SSB tax can't be taxed on an even year and locals are preempted to do it themselves.
Well Ahead Obesity, Diabetes and Tobacco Coalitions- should we combine to develop a Chronic Disease Collaborative and also include HTN since they involve similar partners

NEXT STEPS (TAKING ACTION AND SUSTAINING MOMENTUM)

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

Action Items- Explore Obesity Commission- can we make the group actionable by adding HTN as a focus-

- LDH will lead; AHA (Ashley) to back up

Increased communication amongst us
Hyper focused workgroups
Greater understanding of what's happening and what's needed- attend local coalitions needed
Linking partners to Quality Systems training
Community assessment to identify GAPS- LSU maps
Chamber of Commerce engagement
Engage Coalition Leaders and find a way to communicate with them

- Louisiana Healthy Community Coalitions
- Rapides Foundation

WORKGROUP TEAM ROSTER

Name	Organization	Email Address	Phone #
Colleen Arceneaux	Well- Ahead Louisiana	Coleen.Arceneaux@la.gov	
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Erin Leonard	Well- Ahead Louisiana	Erin.Leonard@la.gov	
Julia Schneider	National Association of Chronic Disease Directors	jschneider@chronicdisease.org	
Bryan Hanaki	Louisiana Healthcare Connections	bryan.m.hanaki@louisianahealthconnect.com	
Hobie Fluitt	Well- Ahead Louisiana	Hobie.Fluitt@la.gov	337-581-4140
Audrey Shields	Well- Ahead Louisiana	Audrey.Shields@la.gov	228-669-3265
Hillary Sutton	Well- Ahead Louisiana	Hillary.Sutton@la.gov	225-342-0935

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

Taylor Reine	Well- Ahead Louisiana	Taylor.Reine@la.gov	
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Robin Rhodes	Well- Ahead Louisiana	Robin.Rhodes@la.gov	225-342-9307

Attendee List:

First Name	Last Name	Organization	Title
Kelly	Flaherty	American Heart Association	Director, Advocacy Operations and Grants
Julie	Harvill	American Heart Association	Operations Manager
Ashley	Hebert	American Heart Association	Government Relations Director
Coretta	LaGarde	American Heart Association	Vice President of Health Strategies
Chelsea	Moreau	American Heart Association	Community Impact Director
Sharon	Nelson	American Heart Association	Program Initiatives Manager
Cindy	Peavy	Arbor Family Health, Innis Community Health Center	executive director
Stacie	Bland	Baton Rouge Primary Care Collaborative, Inc.	Chief Executive Officer
Jasmine	Breaux, FNP	Baton Rouge Primary Care Collaborative, Inc.	Family Nurse Practitioner
Trish	Erwin	Bunkie General Rural Health Clinics	Registered Nurse
Marsha	Gauthier	Bunkie General Rural Health Clinics	Registered Nurse
Veronica	Gillispie-Bell, MD	Louisiana Department of Health	Medical Director, LAPQC and PAMR
Bryan	Hanaki	Louisiana Healthcare Connections	Business Analyst
Bridgette	Bienville	Louisiana Primary Care Association	Health Information Technology Project Manager
Courtney	Sanford	Louisiana Primary Care Association	Clinical Quality Coordinator
John	Clymer	National Forum for Heart Disease & Stroke Prevention	Executive Director
Julia	Schneider	National Association of Chronic Disease Directors	Consultant, Cardiovascular Health
Annie	Gayden	Nightingail Healthcare Resources	Office Manager
Wanda	Smith	Nightingail Healthcare Resources	Family Nurse Practitioner
Susan	Conly	North Caddo Medical Center	Office Manager
Michele	Heflin	North Caddo Medical Center	Licensed Practical Nurse
Kristian	Johnston	North Caddo Medical Center	Office Manager
Jherie	Ducombs	North Oaks Health System	VP/Assistant CMO
Kenny J.	Cole, MD	Ochsner Health System/Ochsner Health Network	System Vice President, Clinical Improvement
Kevin	Lanclos	Opelousas General Health System	Clinical Director of Emergency Services
Tim	Marks	Opelousas General Health System	Chief Pop Health & Clinical Integration Officer
John	Bartkus	Pensivia	Principal Program Manager
Debra	Rushing	Quality Insights, Quality Innovation Network	Cardiac, Louisiana State Lead
Danelle	Guillory	Sankofa Community Development Corporation	Director of Operations
Brian	Burton	Southwest Louisiana Area Health Education Center	Chief Executive Officer
Hobie	Fluitt	Southwest Louisiana Area Health Education Center	Director of Community Resource/ Practice Coach
Tonia	Moore	Tobacco Free Living /Louisiana Public Health Institute	Director
Lydia	Bazzano	Tulane University School of Public Health and Tropical Medicine	Director
Camilo	Fernandez Alonso, MD	Tulane University School of Public Health and Tropical Medicine	Center for Cardiovascular Health
Colleen	Arceneaux	Well-Ahead Louisiana, Louisiana Department of Health	Population Health Manager
Deante	Baham	Well-Ahead Louisiana, Louisiana Department of Health	Provider Engagement Specialist
Nicole	Coarsey	Well-Ahead Louisiana, Louisiana Department of Health	Louisiana State Primary Care Officer
Latraiel	Courtney	Well-Ahead Louisiana, Louisiana Department of Health	Quality Improvement Manager
Marie	Darr	Well-Ahead Louisiana, Louisiana Department of Health	Health Systems Consultant
Marcy	Hubbs	Well-Ahead Louisiana, Louisiana Department of Health	Provider Education Network Manager
Kaitlyn	King	Well-Ahead Louisiana, Louisiana Department of Health	Community Navigation Coordinator
Erin	Leonard	Well-Ahead Louisiana, Louisiana Department of Health	Heart Disease Manager
Melissa	Martin	Well-Ahead Louisiana, Louisiana Department of Health	Director
Dana	O'Neal	Well-Ahead Louisiana, Louisiana Department of Health	Chronic Disease Practice Coach
Taylor	Reine	Well-Ahead Louisiana, Louisiana Department of Health	Cessation Coordinator
Audrey	Shields	Well-Ahead Louisiana, Louisiana Department of Health	Community Engagement Specialist
Hillary	Sutton	Well-Ahead Louisiana, Louisiana Department of Health	Division Manager for Health Education
Rebecca	Wilkes	Well-Ahead Louisiana, Louisiana Department of Health	Practice Coach
Julie	Domma Russell	YMCA of the Capital Area	Executive Director of Healthy Lifestyles

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

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

8:30 am – Networking
9:00 am – Meeting Starts

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Welcome and Opening Remarks

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

2

Welcome and Opening Remarks

JULIE HARVILL
Operations Manager
Million Hearts® Collaboration
American Heart Association

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

3

Overview of the Day

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

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Million Hearts® in Action (2013-2019)

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Purpose and Outcomes

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

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

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Agenda

- Welcome & Overview of the Day
- Introductions
- Million Hearts® 2022 Update
- Louisiana Department of Health Hypertension Initiatives
- Quality Insights, Quality Innovation Network
- American Heart Association Hypertension Initiatives
- Louisiana Partner Hypertension Initiatives
  - Partnering with providers to implement sustainable systems changes
  - Bogalusa Heart Study and Hypertension
  - Louisiana Perinatal Quality Collaborative
  - Sankofa Community Development Corporation
  - Rural Health Center Hypertension Programs
- Lunch @ 12:00 noon
- Facilitated Discussions / Breakouts (x3)
- Group Report Outs and Next Steps
- Evaluation and Feedback Process
- Wrap up / Adjourn

7

Introductions

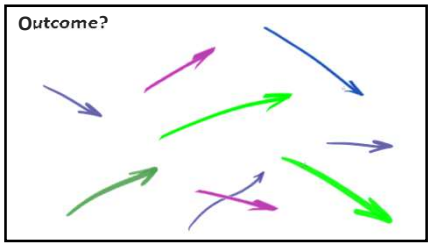
JOHN BARTKUS
Principal Program Manager
Pensivia

8

Alignment

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

9



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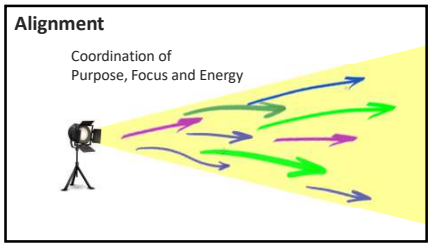

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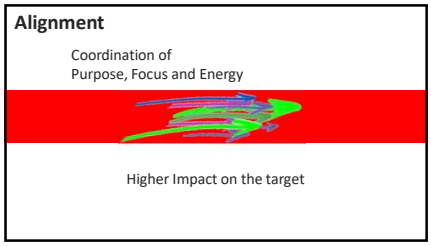

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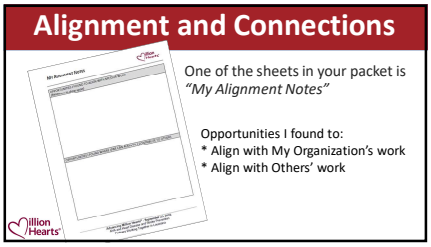

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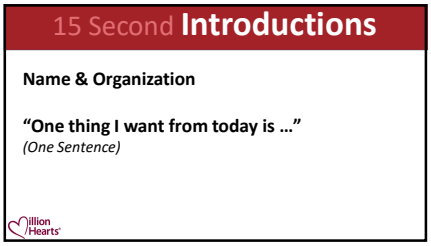

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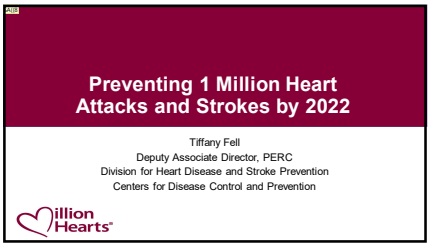

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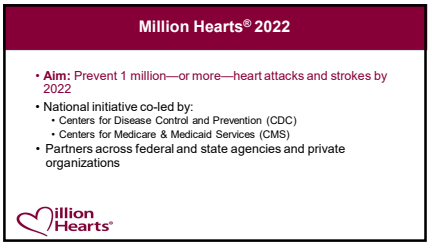

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Slide 17

SA((8 I changed the last sentence of the notes to be more in line with Louisiana's program (old Utah slidedeck)
Stokfisz, Andrea (CDC/DDNID/NCCDPHP/DHDSP) (CTR), 9/23/2019

Heart Disease and Stroke in the U.S.

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

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

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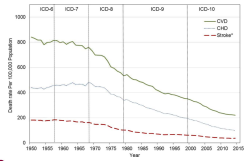
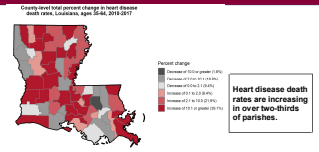
Heart Disease and Stroke Trends 1950–2015



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

20

Parish-level death rates



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

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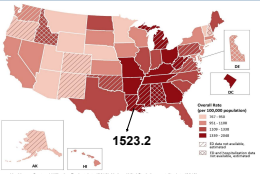
Million Hearts-preventable event rates among adults aged ≥18 years by state, 2016



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

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What this means for Louisiana

- We project **279,300** "Million Hearts preventable events" that will occur in LA if we do nothing
- 6% reduction of those events = **16,800 events** we hope LA will prevent

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Million Hearts® 2022 *Priorities*

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

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

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Keeping People Healthy

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

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Optimizing Care

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

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

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Improving Outcomes for Priority Populations

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

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Million Hearts®
Resources and Tools

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

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

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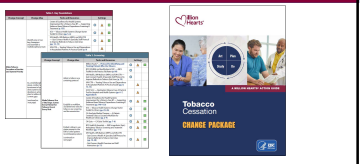
Tobacco Cessation Change Package (TCCP)



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

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Million Hearts® SMBP Forum

- **Meets quarterly** to facilitate the exchange of SMBP best practices, tools, and resources
- **Join the SMBP Forum at** http://bit.ly/SMBPForum
- **Access materials via the SMBP Healthcare Community**
  - Go to www.healthcarecommunities.org and log in to your account (free to register)
  - Search for 'SMBP' under the 'Available Communities' tab
  - Click "Join Community"
- **Questions:** MillionHeartsSMBP@nachc.org

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Million Hearts® in Municipalities Toolkit

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

NACCHO

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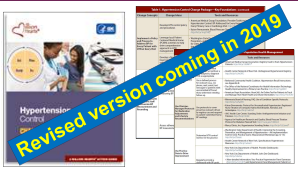
Hypertension Control Change Package



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

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Million Hearts® Hospitals & Health Systems

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

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

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

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Application Process

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

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

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Million Hearts® for Clinicians Microsite

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

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Stay Connected

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

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Louisiana Department of Health Hypertension Initiatives

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

Million Hearts

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Connecting Louisiana Residents to a Heathier Future

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

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WELL-AHEAD
WELLAHEADLA.COM

Connecting Louisiana Communities to a Healthier Future,
a focus on Heart Disease Prevention and Management

Louisiana's Health Initiative

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Louisiana Data

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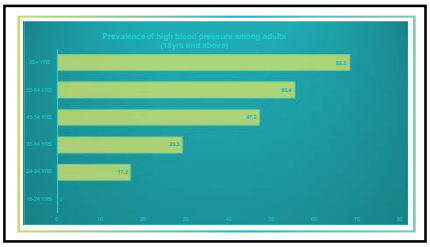

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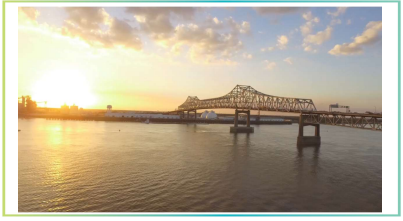

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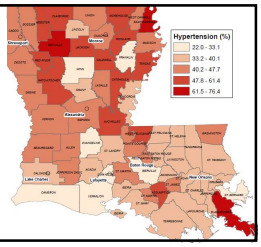
Prevalence of High Blood Pressure by Parish amongst Louisiana Adults 18 years and older

Source: BRFSS 2015, 2017



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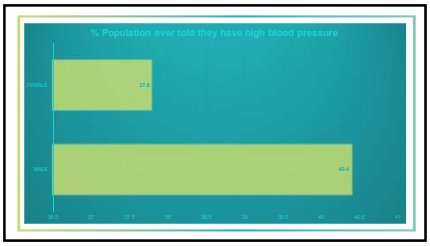

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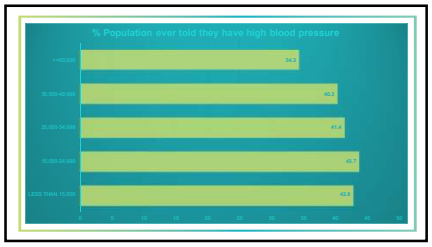

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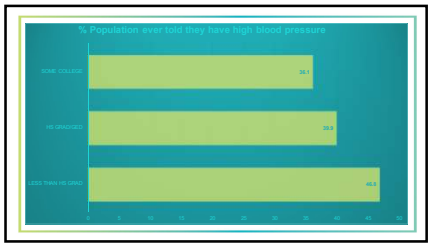

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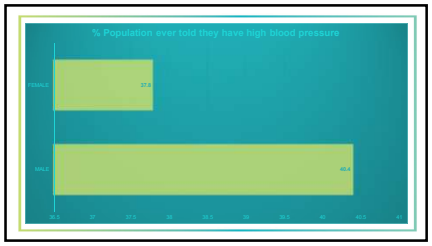

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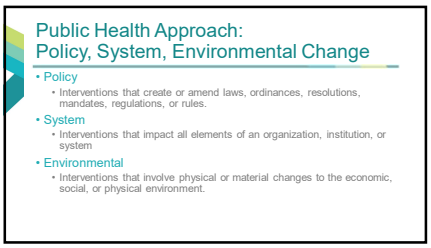

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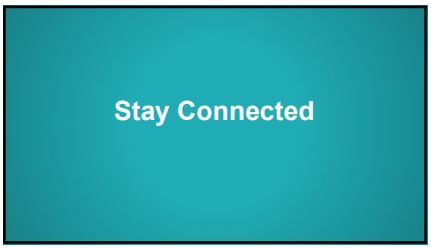

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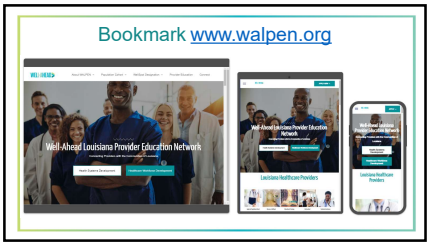

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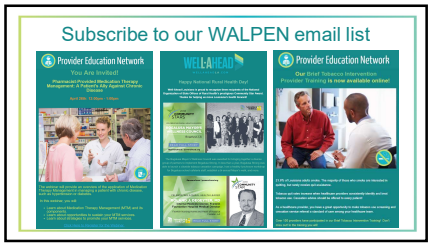

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Quality Insights, Quality Innovation Network

DEBRA RUSHING, RN, MBA
Cardiac, Louisiana State Lead

Million Hearts

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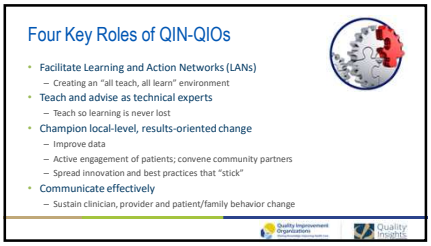

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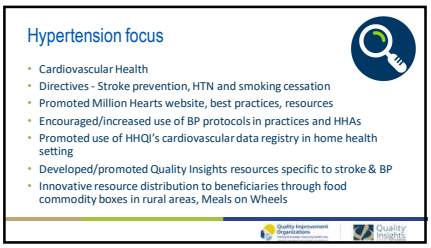

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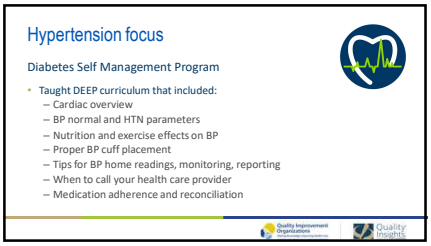

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CMS Medicare Quality Improvement Projects on the Horizon

5 Broad Aims

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

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CMS Medicare Quality Improvement Projects on the Horizon

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

65

Questions

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Quality Improvement Organizations | Quality Insights

www.qualityinsights-qin.org

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American Heart Association Hypertension Initiatives

Ashley Hebert, MPA
Government Relations Director
Louisiana

Coretta LaGarde
Vice President,
Health Strategies
Louisiana

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Programs and Resources that Align with Million Hearts

American Heart Association

Coretta LaGarde
Vice President, Health Strategies
Louisiana

Ashley Hebert
Director, Government Relations
Louisiana

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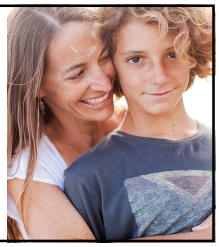
American Heart Association.

Who we are

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

Our Mission

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



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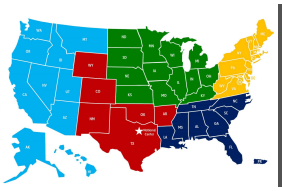
Our levels of work



National – Dallas HQ
Education & awareness
Research management
Quality & science
Advocacy agenda
Strategic partnerships & alliances

5 regions
Activate advocacy
State and affiliate education
Quality improvement
Regional projects

Local
Grassroots advocacy
Fundraising & education
Building partnerships
Recruiting volunteers
Community health

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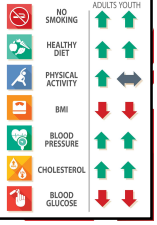
Trends in health improvements

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



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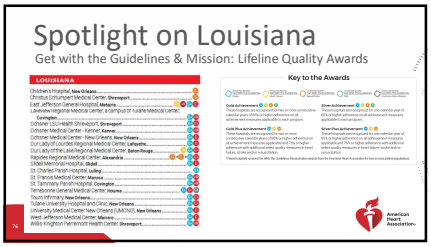

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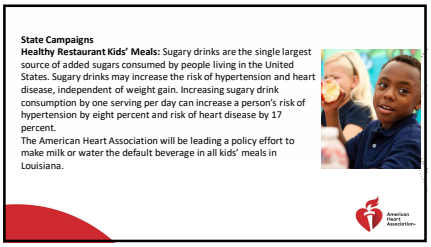

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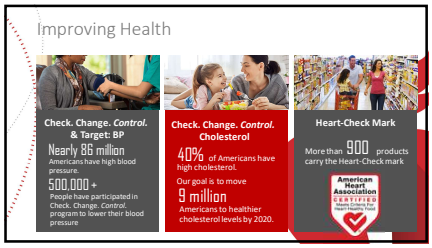

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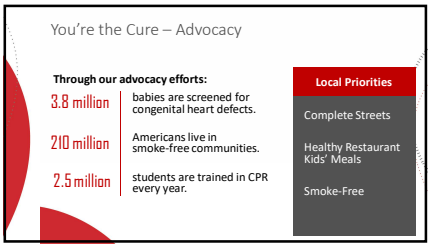

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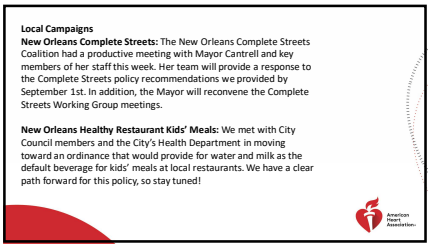

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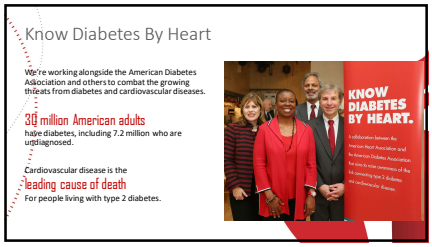

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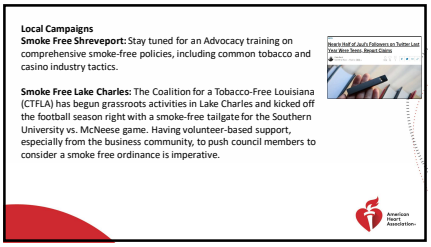

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Tools and Resources

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

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

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Discussion

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

83

Contact Information

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Coretta.Lagarde@heart.org

Ashley Hebert
Ashley.Hebert@heart.org

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Break

Resume at 10:45 am

85

Louisiana Partner Hypertension Initiatives

86

Partnering with Providers to Implement Sustainable Systems Changes

KENNY J COLE, MD, MHCDS
System VP, Clinical Improvement
Ochsner Health System

87

Life in Louisiana

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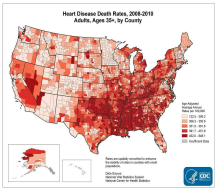
Louisiana's Cardiovascular Crisis



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Measure Up Pressure Down

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

AMGA AMGF

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80% of Patients at Goal Blood Pressure

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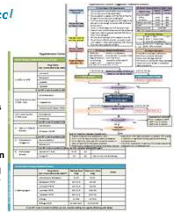
Evidence-Based Protocol

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



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Registry of Uncontrolled Patients

MD #25 Electronic Medical Record — October 20, 2014

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

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

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Nursing Telephonic Outreach for Patient Engagement

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

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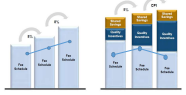
Quality Blue Primary Care

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

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

Care Delivery Innovation: *Value-Based Payment*

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



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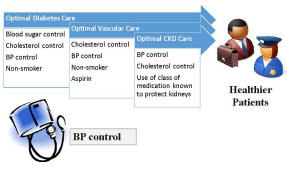
Initial Clinical Outcomes Measures



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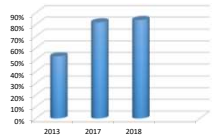
Rates of Hypertension Control



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Bogalusa Heart Study and Hypertension

CAMILO FERNANDEZ ALONSO, MD MS
Department of Epidemiology, Center for Cardiovascular Health
Tulane University School of Public Health and Tropical Medicine
New Orleans, Louisiana

Million Hearts

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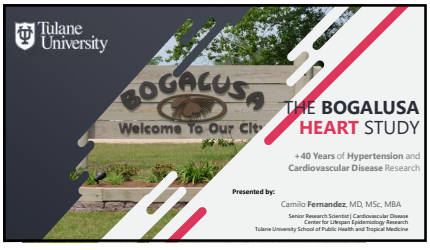

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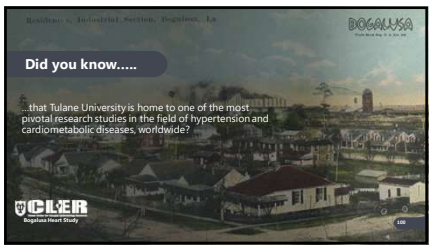

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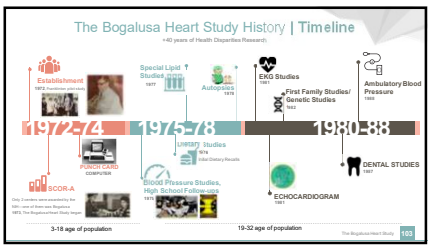

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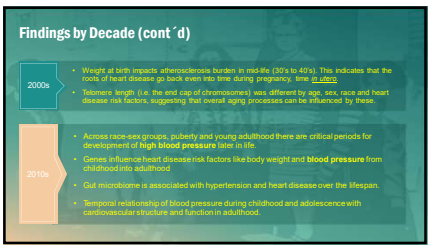

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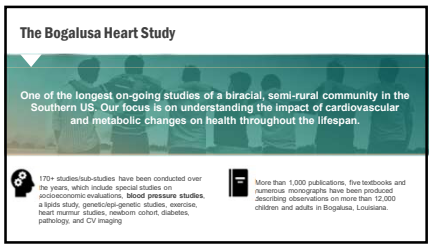

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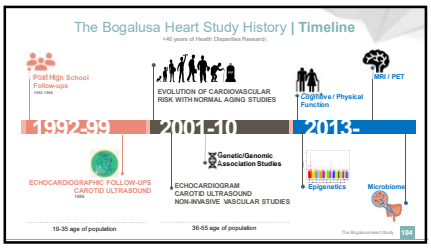

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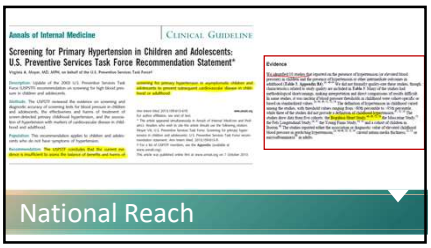

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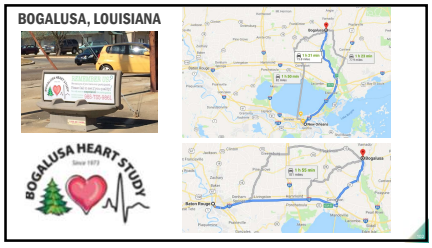

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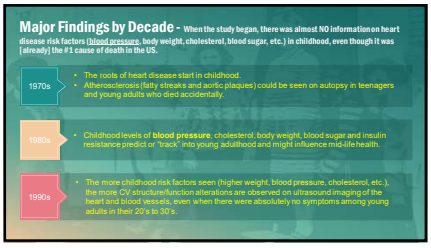

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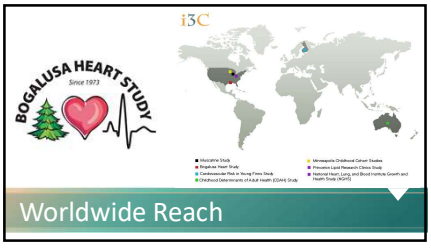

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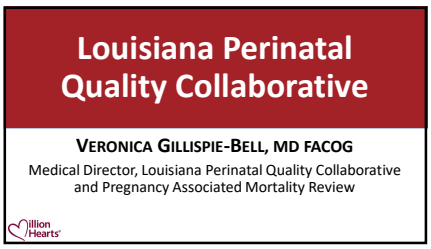

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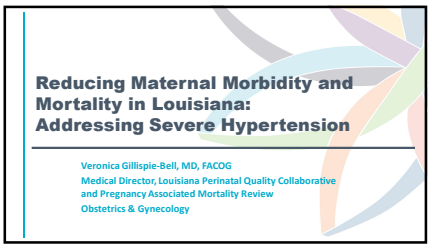

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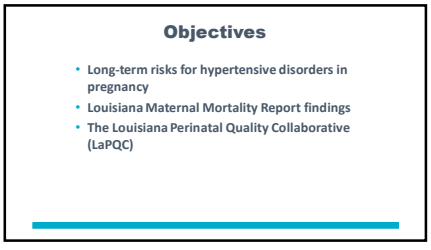

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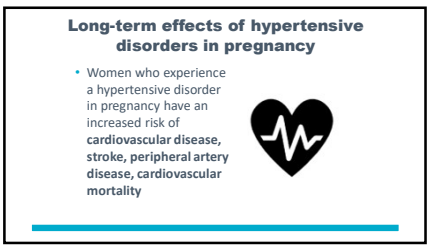

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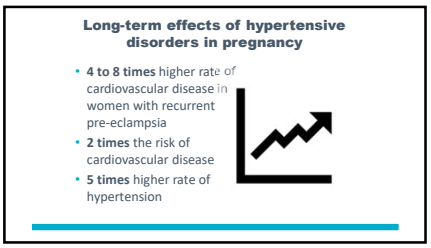

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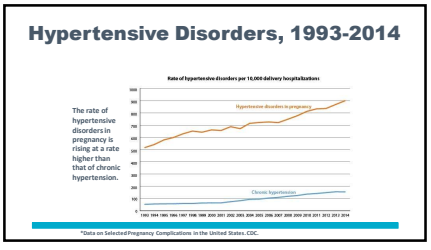

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LOUISIANA MATERNAL MORTALITY REVIEW REPORT

2011-2016

KEY FINDINGS

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

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LOUISIANA MATERNAL MORTALITY REVIEW REPORT

2011-2016

KEY FINDINGS

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

45% were deemed to be preventable

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LOUISIANA MATERNAL MORTALITY REVIEW REPORT

2011-2016

KEY FINDINGS

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

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Louisiana Perinatal Quality Collaborative (LaPQC)

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

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Altering Outcomes

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

National Findings

Based on data from review committees in 9 other states and cities[2]

- 70% of deaths due to **hemorrhage** were thought to be **preventable**.
- 68.2% of deaths due to **cardiovascular/coronary conditions** were thought to be **preventable**.
- 66% of deaths **occurring within 42 days of pregnancy** were thought to be **preventable**.

Louisiana Findings

- 62.5% of **hemorrhage** deaths were deemed **preventable**.
- 62.5% of **cardiomyopathy** deaths were deemed **preventable**.
- 40% of deaths due to **cardiovascular/coronary conditions** were deemed **preventable**.

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

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Why do health disparities exist?

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

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Louisiana Perinatal Quality Collaborative (LaPQC)

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

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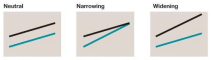
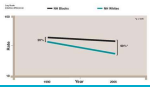
Change = Improvement + Equity



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



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

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Louisiana Perinatal Quality Collaborative (LaPQC)

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

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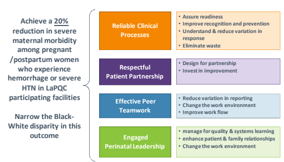
LaPQC Change Package



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Change Goals

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

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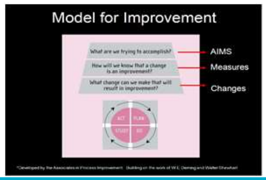
BTS: Model for Improvement



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Hypertension in Pregnancy Toolkit

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

Readiness
Recognition
Response
Reporting

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Call to Action

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

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Our Fundamental Agreements

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

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References

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6. CMQCC Preeclampsia ToolKit: Preeclampsia Care Guidelines
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8. Emergent Therapy for acute-onset, severe hypertension during pregnancy and the postpartum period. Committee Opinion No. 623. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015; 125: 521-5.
9. Gestational hypertension and preeclampsia. ACOG. Practice Bulletin No. 202. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019; 133:e1-25.

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Sankofa Community Development Corporation

Danelle Guillory, MD, PhD
Healthy HeartBeats Program

Million Hearts

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Sankofa Community Development Corporation

Presentation Link...

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Rural Health Center Hypertension Programs

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

Million Hearts

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WELL-AHEAD
WELLAHEADLA.COM

Activities to impact heart disease in the clinical setting

Louisiana's Health Initiative

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Quality Improvement: Focus on NQI Measures

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

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Quality Improvement: Focus on NQI Measures

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

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Quality Improvement: Focus on NQI Measures

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Quality Improvement: Focus on NQI Measures

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

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

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Quality Improvement: Focus on NQI Measures

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

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Million Hearts: Hiding in Plain Sight

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Million Hearts: Hiding in Plain Sight

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

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Million Hearts: Hiding in Plain Sight

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

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Million Hearts: Hiding in Plain Sight

- Outcomes:
  - Identified 100 patients with potentially undiagnosed hypertension

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

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Million Hearts: Hiding in Plain Sight

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

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Conclusion

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

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Almost Lunch

Logistics – Preparing for Afternoon Workgroups

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

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

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Really Really Close to Lunch

For the Low, Low Price of a Group Photo!

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Lunch

Resume at 12:45 pm

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Afternoon Breakouts / Facilitated Discussions

John Bartkus
Principal Program Manager
Pensivia

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Breakout Workgroups

Topics based on the LA planning committee priorities…

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

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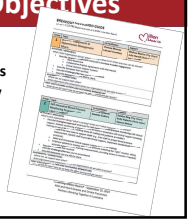
Workgroup Objectives

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



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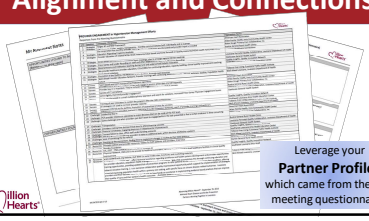
Alignment and Connections



Leverage your **Partner Profiles** which came from the pre-meeting questionnaire.

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Breakout Workgroups

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

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Group Report Outs

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

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

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Evaluation and Feedback Process

Sharon Nelson
Program Initiatives Manager, Million Hearts® Collaboration
American Heart Association

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Wrap Up / Adjourn

Sharon Nelson
Program Initiatives Manager, Million Hearts® Collaboration
American Heart Association

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Advancing Million Hearts® - Louisiana - Partner Profile (from Pre-Meeting Questionnaire)

American Heart Association

Respondent(s): Coretta LaGarde

Organization Type *Indicate all that apply*

	Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
	Community Health Center, Non-FQHC
	Multi-Specialty Practice
	Primary Care Practice
	Specialty Practice
	Residency Practice
	Academic Medical Center
	Health Care System
	Department of Health
Yes	National Non-Profit focused on Heart Disease and Stroke

Provider Engagement

Yes	*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*
Strategies/Approaches:	Target: BP and MAP Framework
Successes:	Team-based approach incorporating treatment algorithms
Challenges/Barriers:	Leadership Buy-In
Resources to Share:	Printable patient and provider resources; Videos for both patients and providers; Free CEUs

SMBP Programs

Yes	*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*
Strategies/Approaches:	Empower Patients to Self-Manage
Priority Audience:	Hypertensive Patients
Successes:	Reduce Staff Burden and Serve as a Resource for Patients
Challenges/Barriers:	Training Strategies to be Deployed
Resources to Share:	SMBP Training Videos in Engligh and Spanish

Clinical-Community Partnerships

Yes	*Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*
Strategies/Approaches:	Food Insecurity Screening & Linkages
Priority Audience:	Food Insecure
Successes:	Increased Access to Healthy Food
Challenges/Barriers:	Transportation
Resources to Share:	Directory to Food Banks in South Louisiana

Other

Other Strategies:	Mesuring Blood Pressure Accurately
Partners:	Well-Ahead Louisiana; Feeding Louisiana; Second Harvest Food Bank

Arbor Family Health, Innis Community Health Center

Respondent(s): Cindy Peavy

Organization Type

Indicate all that apply

Yes	Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
	Community Health Center, Non-FQHC
	Multi-Specialty Practice
	Primary Care Practice
	Specialty Practice
	Residency Practice
	Academic Medical Center
	Health Care System
	Department of Health

Provider Engagement

Yes	*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*
Strategies/Approaches:	High focus on quality, metrics, transparancy. monthly communicatuion both individually and as a group.
Successes:	providers more willing to address issues and engage in process when data shared frequently
Challenges/Barriers:	PCP provider reliance on specialists to make decisions that can be made at the PCP level.
Resources to Share:	

SMBP Programs

Yes	*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*
Strategies/Approaches:	
Priority Audience:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

Clinical-Community Partnerships

Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?

Strategies/Approaches:	
Priority Audience:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

Other

Other Strategies:	
Partners:	

Baton Rouge Primary Care Collaborative, Inc.

Respondent(s): Stacie Bland

Organization Type

Indicate all that apply

Yes	Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
	Community Health Center, Non-FQHC
	Multi-Specialty Practice
	Primary Care Practice
	Specialty Practice
	Residency Practice
	Academic Medical Center
	Health Care System
	Department of Health

Provider Engagement

Yes	*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*
Strategies/Approaches:	Our corporation has monthly provider meetings. All new endeavors are discussed and provider input is included
Successes:	Provider buy in is important. They're inclusion and suggestions have resulted in success.
Challenges/Barriers:	Some challenges are when providers just don't want to engage/perform the task presented or feel a certain endeavor is time consuming
Resources to Share:	

SMBP Programs

Yes	*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*
Strategies/Approaches:	Our organization have care plans and B/P logs for our HTN patiets. Care plan goals are updated at each visit and b/p logs evaluated and analyzed.
Priority Audience:	The patient and staff
Successes:	We have an increase in b/p management with patient accountability. We have found patients are more compliant when they have to bring their log for analysis.
Challenges/Barriers:	Non-compliance
Resources to Share:	

Clinical-Community Partnerships

No	*Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*
Strategies/Approaches:	
Priority Audience:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

Other

Other Strategies:	Patient education and educational material is given at each office visit
Partners:	

Bunkie General Rural Health Clinics

Respondent(s): Marsha Gauthier

Organization Type

Indicate all that apply

	Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
	Community Health Center, Non-FQHC
	Multi-Specialty Practice
	Primary Care Practice
	Specialty Practice
	Residency Practice
	Academic Medical Center
	Health Care System
	Department of Health
Yes	Rural Health Clinic

Provider Engagement

Yes	*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*
Strategies/Approaches:	Education Regarding Programs Available
Successes:	Success of PT compliance
Challenges/Barriers:	Transportation
Resources to Share:	Rapides Foundation

SMBP Programs

Yes	*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*
Strategies/Approaches:	EDUCATION ABOUT SELF REPORTING WHEN OUT OF RANGE
Priority Audience:	UNCONTROLLED BP
Successes:	
Challenges/Barriers:	FINANCIAL
Resources to Share:	

Clinical-Community Partnerships

No	*Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*
Strategies/Approaches:	
Priority Audience:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

Other

Other Strategies:	PROGRAM CALLED HEALTHY LIFESTYLE
Partners:	RAPIDES FOUNDATION

Louisiana Perinatal Quality Collaborative, Louisiana Department of Health

Respondent(s): Veronica Gillispie-Bell, MD

Organization Type

Indicate all that apply

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	Community Health Center, Non-FQHC
	Multi-Specialty Practice
	Primary Care Practice
	Specialty Practice
	Residency Practice
	Academic Medical Center
	Health Care System
Yes	Department of Health

Provider Engagement

Yes	*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*
Strategies/Approaches:	Direct email communication; arranging Zoom meetings; plan to arrange regional dinner meetings
Successes:	Some slightly improved provider engagement
Challenges/Barriers:	providers making time during clinical time to attend learning sessions
Resources to Share:	

SMBP Programs

No	*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*
Strategies/Approaches:	
Priority Audience:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

Clinical-Community Partnerships

No	*Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*
Strategies/Approaches:	
Priority Audience:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

Other

Other Strategies:	
Partners:	

Louisiana Healthcare Connections

Respondent(s): Bryan Hanaki

Organization Type

Indicate all that apply

	Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
	Community Health Center, Non-FQHC
	Multi-Specialty Practice
	Primary Care Practice
	Specialty Practice
	Residency Practice
	Academic Medical Center
	Health Care System
	Department of Health
Yes	Medicaid Managed Care Organization

Provider Engagement

Yes	*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*
Strategies/Approaches:	Provider education of related NCQA HEDIS measures/value based payments focused on Quality measures/HEDIS Health Fairs/Free Clinics
Successes:	
Challenges/Barriers:	
Resources to Share:	

SMBP Programs

No	*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*
Strategies/Approaches:	
Priority Audience:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

Clinical-Community Partnerships

Yes	*Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*
Strategies/Approaches:	MetroMorphosis/Urban Congress Hair & Health sponsorship
Priority Audience:	African-American men
Successes:	
Challenges/Barriers:	
Resources to Share:	

Other

Other Strategies:	
Partners:	LPCA, AHA, MetroMorphosis

Louisiana Primary Care Association

Respondent(s): Bridgette Bienville

Organization Type *Indicate all that apply*

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	Community Health Center, Non-FQHC
	Multi-Specialty Practice
	Primary Care Practice
	Specialty Practice
	Residency Practice
	Academic Medical Center
	Health Care System
	Department of Health
Yes	Louisiana Primary Care Association

Provider Engagement

Yes	*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*
Strategies/Approaches:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

SMBP Programs

Yes	*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*
Strategies/Approaches:	Currently 1-2 health centers are implementing the Remote Patient Monitoring Program through Certintell which involves remote BP monitoring; We are currently introducing this to other health centers in Louisiana
Priority Audience:	Federally Qualified Health Centers and their respective hypertensive patient population
Successes:	This program is fairly new so we don't have any data right now to show.
Challenges/Barriers:	This program is fairly new so we don't have information on this right now. We will send out a survey once we get enough health centers on the Certintell platform to collect this information.
Resources to Share:	We are currently in partnerhsip with Certintell Telehealth. We also partner with the Louisiana Department of Health for the 1815 grant that we manage which covers hypertension and diabetes in the FQHC patient population.

Clinical-Community Partnerships

Yes	*Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*
Strategies/Approaches:	We have partnered with Certintell Telehealth for chronic care management of hypertensive and diabetic patients as well as Remote Patient Monitoring for blood pressure, diabetes, weight management, etc.
Priority Audience:	Federal Qualified Health Centers patient population for hypertension.
Successes:	This partnership occurred within the last month so we don't have any information on success stories yet.
Challenges/Barriers:	This partnership occurred within the last month so we don't have any information on challenges/barriers yet.
Resources to Share:	Certintell staff, FQHC staff (LCSW, Medical Assistants, HIT staff, Quality staff

Other

Other Strategies:	The Director of Quality normally provides trainings for providers on evidence-based practices for chronic disease management.
Partners:	Louisiana Department of Health, MCO's, etc.

Nightingail Healthcare Resources

Respondent(s): Wanda Smith

Organization Type

Indicate all that apply

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	Multi-Specialty Practice
Yes	Primary Care Practice
	Specialty Practice
	Residency Practice
	Academic Medical Center
	Health Care System
	Department of Health

Provider Engagement

No *Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*

Strategies/Approaches:
Successes:
Challenges/Barriers:
Resources to Share:

SMBP Programs

No *Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*

Strategies/Approaches:
Priority Audience:
Successes:
Challenges/Barriers:
Resources to Share:

Clinical-Community Partnerships

No *Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*

Strategies/Approaches:
Priority Audience:
Successes:
Challenges/Barriers:
Resources to Share:

Other

Other Strategies: Life style changes, diet, exercise and compliance with medications
Partners:

North Oaks Health System

Respondent(s): Jherie Ducombs

Organization Type

Indicate all that apply

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	Community Health Center, Non-FQHC
Yes	Multi-Specialty Practice
	Primary Care Practice
	Specialty Practice
	Residency Practice
	Academic Medical Center
	Health Care System
	Department of Health

Provider Engagement

No *Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*

Strategies/Approaches:
Successes:
Challenges/Barriers:
Resources to Share:

SMBP Programs

Yes *Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*

Strategies/Approaches: participate in Target: BP
Priority Audience: primary care and cardiology patients
Successes: overall bp reduction
Challenges/Barriers: organization-wide education
Resources to Share:

Clinical-Community Partnerships

No *Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*

Strategies/Approaches:
Priority Audience:
Successes:
Challenges/Barriers:
Resources to Share:

Other

Other Strategies:
Partners:

Organization Type

Indicate all that apply

	Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
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	Primary Care Practice
	Specialty Practice
	Residency Practice
	Academic Medical Center
	Health Care System
	Department of Health
Yes	Medicare Quality Improvement Organization

Provider Engagement

Yes	*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*
Strategies/Approaches:	Blood pressure and medication teaching during rural and underserved Diabetic Education
Successes:	Training of peer educators to sustain the program after the CMS contract ends.
Challenges/Barriers:	Transportation to class, office staff understanding protocols
Resources to Share:	UIC, DEEP https://mwlatino.uic.edu/deep-program-2/

SMBP Programs

Yes	*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*
Strategies/Approaches:	
Priority Audience:	rural and underserved medicare beneficiaries
Successes:	
Challenges/Barriers:	
Resources to Share:	

Clinical-Community Partnerships

No	*Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*
Strategies/Approaches:	
Priority Audience:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

Other

Other Strategies:	
Partners:	

Tobacco Free Living /Louisiana Public Health Institute

Respondent(s): Tonia Moore

Organization Type

Indicate all that apply

	Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
	Community Health Center, Non-FQHC
	Multi-Specialty Practice
	Primary Care Practice
	Specialty Practice
	Residency Practice
	Academic Medical Center
	Health Care System
	Department of Health
Yes	Louisiana Public Health Institute

Provider Engagement

Yes	*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*
Strategies/Approaches:	Promotion of the Quitline, Fax Referrals to the Quitline, Promote quit resources
Successes:	Increased referrals to the quitline; Promotion of counseling services for smokers
Challenges/Barriers:	ease of comleting the fax referral
Resources to Share:	www.quitwithusla.org website; Quit With Us social media sites; brochures and marketing materials

SMBP Programs

No	*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*
Strategies/Approaches:	
Priority Audience:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

Clinical-Community Partnerships

No	*Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*
Strategies/Approaches:	
Priority Audience:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

Other

Other Strategies:	none
Partners:	none1

Tulane University School of Public Health and Tropical Medicine

Respondent(s): Dr. Camilo Fernandez

Organization Type

Indicate all that apply

- Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
- Community Health Center, Non-FQHC
- Multi-Specialty Practice
- Primary Care Practice
- Specialty Practice
- Residency Practice
- Academic Medical Center
- Health Care System
- Department of Health

Yes Tulane University, Bogalusa Heart Study

Provider Engagement

No *Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*

Strategies/Approaches:
Successes:
Challenges/Barriers:
Resources to Share:

SMBP Programs

No *Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*

Strategies/Approaches:
Priority Audience:
Successes:
Challenges/Barriers:
Resources to Share:

Clinical-Community Partnerships

Yes *Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*

Strategies/Approaches: The partnership facilitates training local barbers to take blood pressure.
Priority Audience: Our priority audience is hypertensive men with a focus on African Americans.
Successes: Partnership in the community-clinical area is a success in itself. While the program is still in its infancy, a variety of community and clinical stakeholders participate.
Challenges/Barriers: One challenge is that the clinical area is new to some community stakeholders.
Resources to Share: N/A

Other

Other Strategies: All BHS participants have blood pressure measured and are referred to care if elevated.
Partners: Well Ahead Louisiana, Our Lady of the Angels

Opelousas General Health System

Respondent(s): Jackie Harbour, RN; Kevin J. Lanclos, RN

Organization Type

Indicate all that apply

	Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
	Community Health Center, Non-FQHC
Yes	Multi-Specialty Practice
	Primary Care Practice
	Specialty Practice
	Residency Practice
	Academic Medical Center
Yes	Health Care System
	Department of Health
Yes	General Hospital

Provider Engagement

Yes	*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*
Strategies/Approaches:	Press Ganey and Leader Rounding on staff and other departments; Quarterly Physician Rounding
Successes:	Issues are discussed in a small multidisciplinary approach and search for solutions; Increased Press Ganey Physician Engagement Scores
Challenges/Barriers:	Financial constraints; Engaging physicians in departmental improvements
Resources to Share:	

SMBP Programs

No	*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*
Strategies/Approaches:	
Priority Audience:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

Clinical-Community Partnerships

No	*Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*
Strategies/Approaches:	
Priority Audience:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

Other

Other Strategies:	Patient education sessions held by physicians and health fairs
Partners:	Local physicians

Southwest Louisiana Area Health Education Center

Respondent(s): Brian Burton; Hobie Fluitt

Organization Type

Indicate all that apply

	Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
	Community Health Center, Non-FQHC
	Multi-Specialty Practice
	Primary Care Practice
	Specialty Practice
	Residency Practice
Yes	Academic Medical Center
	Health Care System
Yes	Department of Health
Yes	Community Based Organization / Public Health Foundation

Provider Engagement

Yes	*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*
Strategies/Approaches:	We provide healthcare provider education, CEUs/CMEs for continuing education, capacity building, clinical quality improvement coaching; Well-Ahead initiatives
Successes:	all strategies are used to increase provider capacity
Challenges/Barriers:	the willingness for healthcare providers to take on additional tasks within the time allotted to a patient.
Resources to Share:	Physician Network, CMEs/CEUs to provide to healthcare providers, full time Practice Coach to lead healthcare facilities in clinical quality improvement

SMBP Programs

No	*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*
Strategies/Approaches:	
Priority Audience:	
Successes:	
Challenges/Barriers:	
Resources to Share:	

Clinical-Community Partnerships

Yes	*Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*
Strategies/Approaches:	Partnership with the Louisiana Health Department to work with healthcare centers to identify opportunities for clinical quality improvement measures for hypertension
Priority Audience:	rural health centers
Successes:	Very new project. We are beginning this process
Challenges/Barriers:	This is a very new project
Resources to Share:	N/A at this time

Other

Other Strategies:	
Partners:	

Well-Ahead Louisiana, Louisiana Department of Health

Respondent(s): Kaitlyn King; Erin Leonard; Taylor Reine; Audrey Shields; Rebecca Wilkes

Organization Type

Indicate all that apply

	Federally Qualified Health Center (FQHC) or a designated FQHC Look-Alike
	Community Health Center, Non-FQHC
	Multi-Specialty Practice
	Primary Care Practice
	Specialty Practice
	Residency Practice
	Academic Medical Center
	Health Care System
Yes	Department of Health

Provider Engagement

Yes	*Does your Organization implement strategies to Increase Provider Engagement (individual and health system level)?*
Strategies/Approaches:	Well-Ahead Provider Education Network; Provider trainings with continuing education credits offered, webinars, toolkits; Population Health Cohort
Successes:	Successfull reach in providers involved in WALPEN (Provider Education Network), reach of provider trainings and webinars.
Challenges/Barriers:	Keeping up the momentom. Finding time to implement changes in routine to their daily practice.
Resources to Share:	1. https://www.walpen.org/ - offers technical assistance regarding workforce and health systems development and provides opportunities for provider education, population health management and collaboration. WAL-PEN accomplishes this through continuing education and training opportunities, providing updated lists of prevention programs to refer patients to learn about and manage their condition, offering tobacco cessation training. 2. is an exclusive collaborative quality improvement opportunity which support the implementation of strategies aimed at improving population health within a primary care setting, with specific focus on chronic disease related outcomes. Louisiana providers and their facilities have the opportunity to have hands-on assistance in implementing evidence-based practices that can improve their quality of care and their patient's health outcomes. ; Available tobacco cessation resources.

SMBP Programs

Yes	*Does your Organization promote Self-Measured Blood Pressure Monitoring (SMBP)?*
Strategies/Approaches:	Creation of community clinical linkages utilizing community-based organziation within underserved populations to identify individuals who are at risk.; Provide technical assistance to organizations interested in starting a Self-Measured Blood Pressure Monitoring Program; Community and clinical based practices;
Priority Audience:	African American males with undiagnosed high blood pressure; Barbershops, Faith-Based Organizations, Councils on Aging, senior centers and non-profits; Target populations; African American, Low SES, Chronic Disease; Rural Health Clinics
Successes:	Cutt'n the Pressure in Bogalusa, LA in partnership with Our Lady of Angels Hospital trained 3 barbers to implement SMBP in their shops.
Challenges/Barriers:	Legalities involved in collecting community member PHI for clinical use while ensuring that completion of consent forms is as minimal of a barrier to participation as possible
Resources to Share:	Have created a toolkit to provide a template on how to create a successful SMBP Program.

Clinical-Community Partnerships

Yes	*Does your Organization engage in Community-Clinical Partnerships to increase hypertension management?*
Strategies/Approaches:	Community Resource Coordinators and WISEWOMAN grant; Partnering with specific clinincs to provide resources and interventions to those who have barriers accessing treatments. ; We utilize a community resource coordinator to help assist with locating resources within the region.
Priority Audience:	Low SES, Un or underinsured, chronic disease11; Rural Health Clinics
Successes:	
Challenges/Barriers:	Resources are limited in rural areas.

Well-Ahead Louisiana, Louisiana Department of Health

Respondent(s): Kaitlyn King; Erin Leonard; Taylor Reine; Audrey Shields; Rebecca Wilkes

Resources to Share:	Community Resources Coordinators work in the community to identify NDPP, DSMES and SMBP programs and link those community resources to health care providers. 2. The WISEWOMAN grant provides health screenings to eligibile women to assess their risk for heart disease. Participating women are provided free membership for lifestyle programs, or health coaching to improve their health outcomes.

Other

Other Strategies:	
Partners:	American Heart Association