Welcome!

We will get started promptly at 10am

This material was prepared by the IPRO QIN-QIO, a Quality Innovation Network-Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Registration # 12SOW-IPRO-QIN-T1-A3-23-952

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Partnering Beyond COVID-19: Prevention and Management of Patients with Chronic Conditions

Today's Focus: Heart Health

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- A federally-funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) in contract with the Centers for Medicare & Medicaid Services (CMS)
- 12 regional CMS QIN-QIOs nationally

IPRO:
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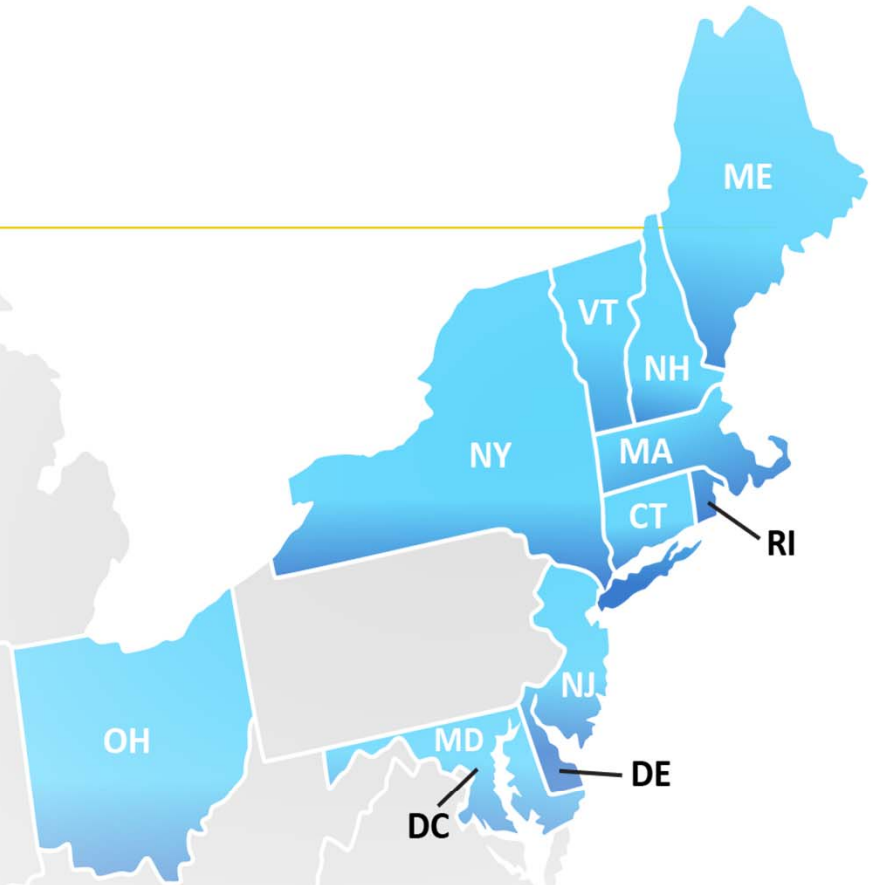
Healthcentric Advisors:
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Qlarant:
Maryland, Delaware, and the District of Columbia



Working to ensure high-quality, safe healthcare for
20% of the nation's Medicare FFS beneficiaries

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Welcome!

- Today's session is being recorded
- Although we want active participation, we ask that you please keep yourself on 'mute' during the presentation
- Please introduce yourself (name, organization & role, location) using the Chat feature

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Managing Chronic Conditions Learning Series

- Prevention and Management Focus
- Hypertension, Chronic Kidney Disease and Diabetes
- Cardiac Rehab
- Role of Nutrition
- Infusing Health Equity Throughout

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Learning Objectives for Today's Session

Upon completion of this session, participants will be able to:

- Implement evidence-based strategies from Million Hearts to improve hypertension outcomes,
- Identify and promote best practices to increase Cardiac Rehabilitation referrals and participation, and
- Build awareness about heart health disparities and identify best practices for addressing these disparities to support better heart health outcomes.

Million Hearts®: Preventing 1 Million Cardiovascular Events by 2027

Haley Stolp, MPH
Health Scientist
Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention

Disclaimer

The opinions expressed by authors contributing to this project do not necessarily reflect the opinions of the Centers for Disease Control and Prevention. Use of trade names is for identification only and does not imply endorsement.

Please use your heart reaction if you know someone who has had a heart attack or stroke.

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Keep your heart up if you know someone who died from a heart attack or stroke.

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60,000 more people died of COVID-19 during 2021 compared with 2020; COVID-19 remained the 3rd leading cause of death

PROVISIONAL 2021 DEATHS

1

Heart Disease

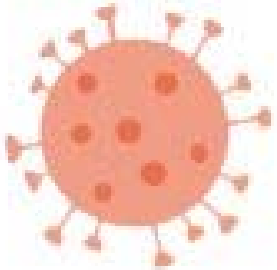
693K

2

Cancer

605K

3



COVID-19

415K

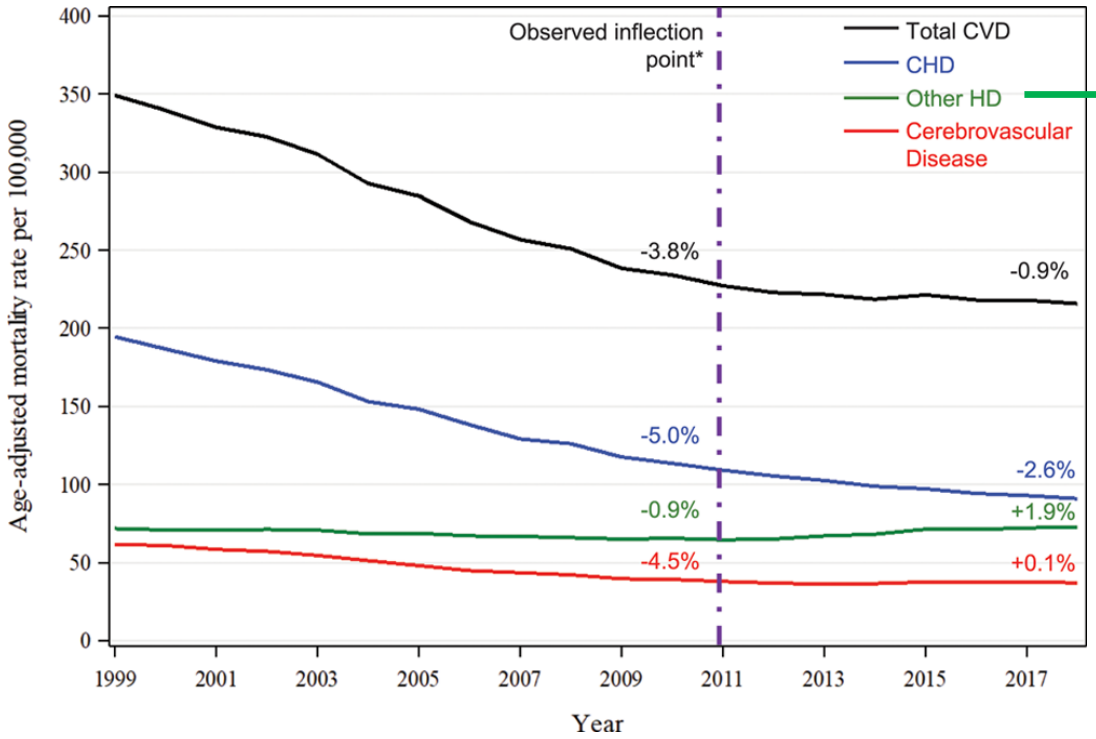
* Provisional National Vital Statistics System (NVSS) death certificate data on underlying causes of death among U.S. residents in the United States during January–December 2021

bit.ly/MMWR7117

APRIL 22, 2022

MMWR

Cardiovascular Disease Mortality 1999-2018



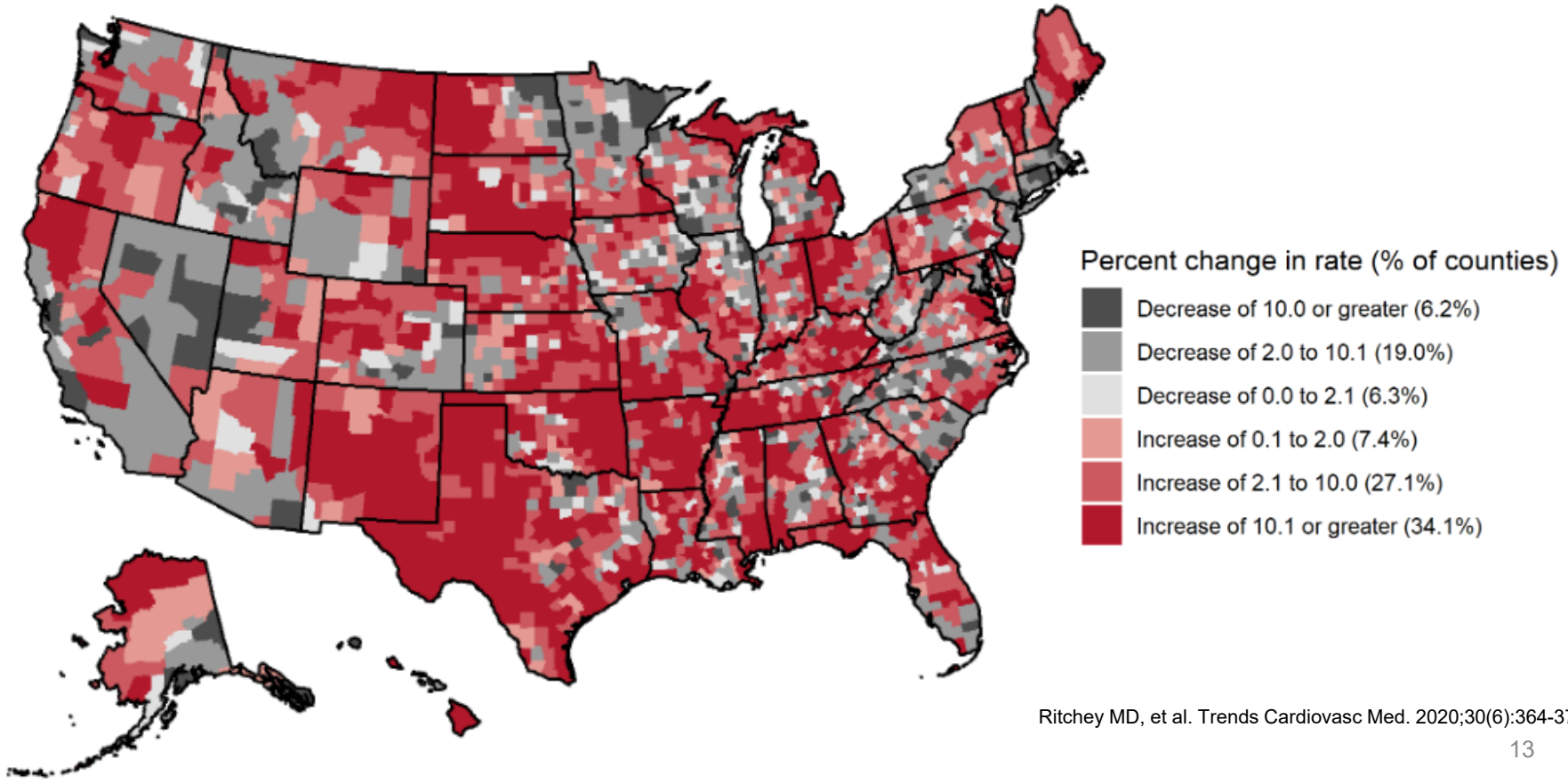
heart failure

Figure 2. Trends in age-adjusted mortality rates per 100 000 population attributable to total cardiovascular disease and to leading subtypes of cardiovascular disease as underlying causes of death in the United States with the average annual percentage change before and after the inflection point* between 1999 to 2011 and 2011 to 2018. Declines in age-adjusted mortality rates per 100 000 population attributable to total cardiovascular disease and to leading subtypes of cardiovascular disease as underlying causes of death in the United States with average annual percentage change before and after the inflection point* between 1999 to 2011 and 2011 to 2018. CHD indicates coronary heart disease; CVD, cardiovascular disease; and HD, heart disease.

Goff DC, et al. Circulation. 2021 Feb 23;143(8):837-851.

Alarming Mortality Rate Changes

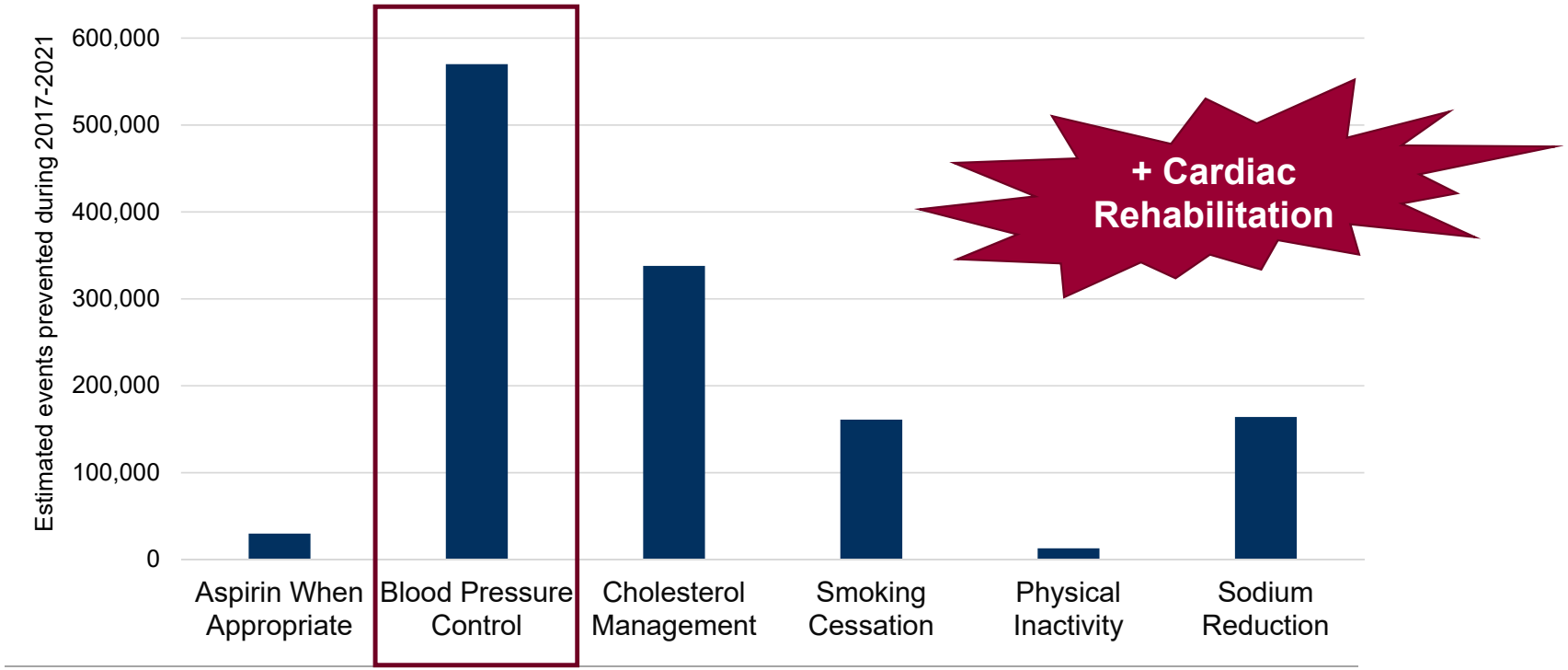
County-level percent change in heart disease death rates, United States, Ages 35-64, 2010-2017



Ritchey MD, et al. Trends Cardiovasc Med. 2020;30(6):364-374.

How can we prevent cardiovascular events?

Contributions Towards A Million Cardiovascular Events



Notes: Aspirin when appropriate reflects aspirin use for secondary prevention only; total does not equal sum of events prevented by risk factor type as those totals are not mutually exclusive; applies ratios obtained from PRISM and ModelHealth:CVD to estimate the number of total events, to more closely align with the Million Hearts event definition

Data sources: Aspirin when appropriate – 2013-14 NHANES; blood pressure control and cholesterol management – 2011-14 NHANES; smoking cessation and physical inactivity – 2015 NHIS, sodium reduction – 2011-12 NHANES.

Million Hearts® 2027 Priorities

Building Healthy Communities
Decrease Tobacco Use
Decrease Physical Inactivity
Decrease Particle Pollution Exposure

Optimizing Care	
Improve Appropriate Aspirin or Anticoagulant Use	
Improve Blood Pressure Control	80%
Improve Cholesterol Management	
Improve Smoking Cessation	
Increase Use of Cardiac Rehabilitation	70%

Focusing On Health Equity

Pregnant and Postpartum Women with Hypertension	People from Racial/Ethnic Minority Groups	People with Behavioral Health Issues Who Use Tobacco	People with Lower Incomes	People Who Live in Rural Areas or Other 'Access Deserts'

Optimizing Care

Goals	Evidence-based Strategies
Improve Appropriate Aspirin or Anticoagulant Use	• Support use of standardized approaches, teams, technology, data, patient supports
Improve Blood Pressure Control	• Support use of standardized approaches, teams, technology, data, patient supports including DPP, SMBP, HIPS (strategies in the **HCCP**) • Improve coverage for antihypertensives, SMBP devices
Improve Cholesterol Management	• Support use of standardized approaches, teams, technology, data, patient supports including DPP, HIPS (strategies in the CMCP) • Improve coverage for lipid-lowering agents
Improve Smoking Cessation	• Support use of standardized approaches, teams, technology, data, patient supports, including HIPS (strategies in the TCCP) • Improve barrier-free coverage for tobacco cessation
Increase Use of Cardiac Rehabilitation	• Support use of automatic referral, care coordination, hybrid CR, program redesign (strategies in the **CRCP**) • Improve coverage for cardiac rehabilitation

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DPP = Diabetes Prevention Program, SMBP = self-measured blood pressure monitoring; HIPS = hiding in plain sight; **HCCP = Hypertension Control Change Package**; CMCP = Cholesterol Management Change Package; TCCP = Tobacco Cessation Change Package; **CRCP = Cardiac Rehabilitation Change Package**

Focusing on Health Equity

Pregnant and Postpartum Women With Hypertension	People from Racial/ Ethnic Minority Groups	People with Behavioral Health Issues Who Use Tobacco	People with Lower Incomes	People who Live in Rural Areas and Other 'Access Deserts'
• **Strategies** • Champion widespread SMBP use • Expand / extend Medicaid coverage • Close gaps in transition of care • Promote aspirin use to prevent preeclampsia	• **Strategies** • SMBP, MTM in trusted spaces • Expand Medicaid coverage • Tailored protocols to increase med intensification / med adherence • Enhance sodium reduction • Policies prohibiting sale of flavored tobacco products	• **Strategies** • Support integration of tobacco cessation treatment into mental health, substance use care • Encourage smoke-free behavioral health facilities • Expand Medicaid coverage	• **Strategies** • Expand Medicaid coverage • Support SMBP device loaner programs • Support inclusion of evidence-based strategies in value-based care delivery	• **Strategies** • Support availability of robust virtual and remote models of cardiac rehabilitation • Support the use of SMBP and related telehealth • Support expanded scopes of practice for NPs, PAs, PharmDs, and CHWs

Hypertension

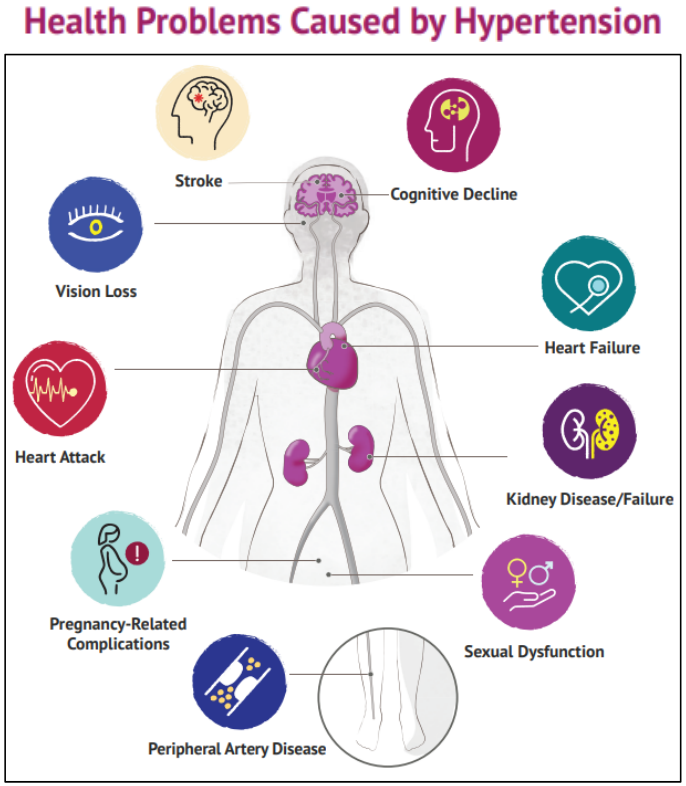
U.S. Burden of Hypertension

Using ≥130/80 mmHg:

- ~44% prevalence among US adults → ~108M adults
  - 56% among adults 45-64
  - 78% among adults 65+
  - 53% among non-Hispanic blacks

Of the 87M recommended to be on medications and LMs:

- ~71% are uncontrolled → ~61M adults



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Are these people in care?

Among people with hypertension (NHANES 2017-18):

- 90.8% – had usual healthcare provider
- 93.2% – had a visit in the last year

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Muntner P, et al. Trends in Blood Pressure Control Among US Adults With Hypertension, 1999-2000 to 2017-2018. JAMA. 2020 Sep 22;324(12):1190-1200.

2022 Million Hearts® Hypertension Control Champions

- Cardiovascular Institute of the South, Houma, LA
- Cardiovascular Institute of the South, Meridian, MS
- Community Health Center of Southeast Kansas, Pittsburg, KS
- Forest Park Internal Medicine and Pediatrics, Cincinnati, OH
- Manu Seghal, MD, Milford, DE
- Norton Sound Health Corporation, Nome, AK
- Stonecreek Family Physicians, Manhattan, KS
- Sunrise Medical PC, Corona, NY
- Valley Professionals Community Health Center - N Terre Haute, Terre Haute, IN

https://millionhearts.hhs.gov/partners-progress/champions/index.html

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

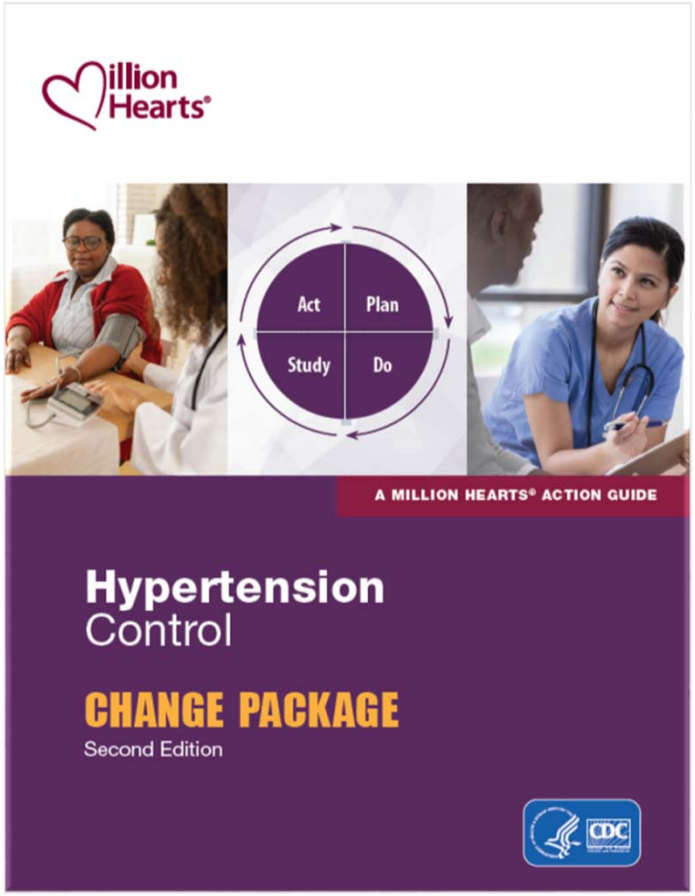


Table 1. Key Foundations (continued)

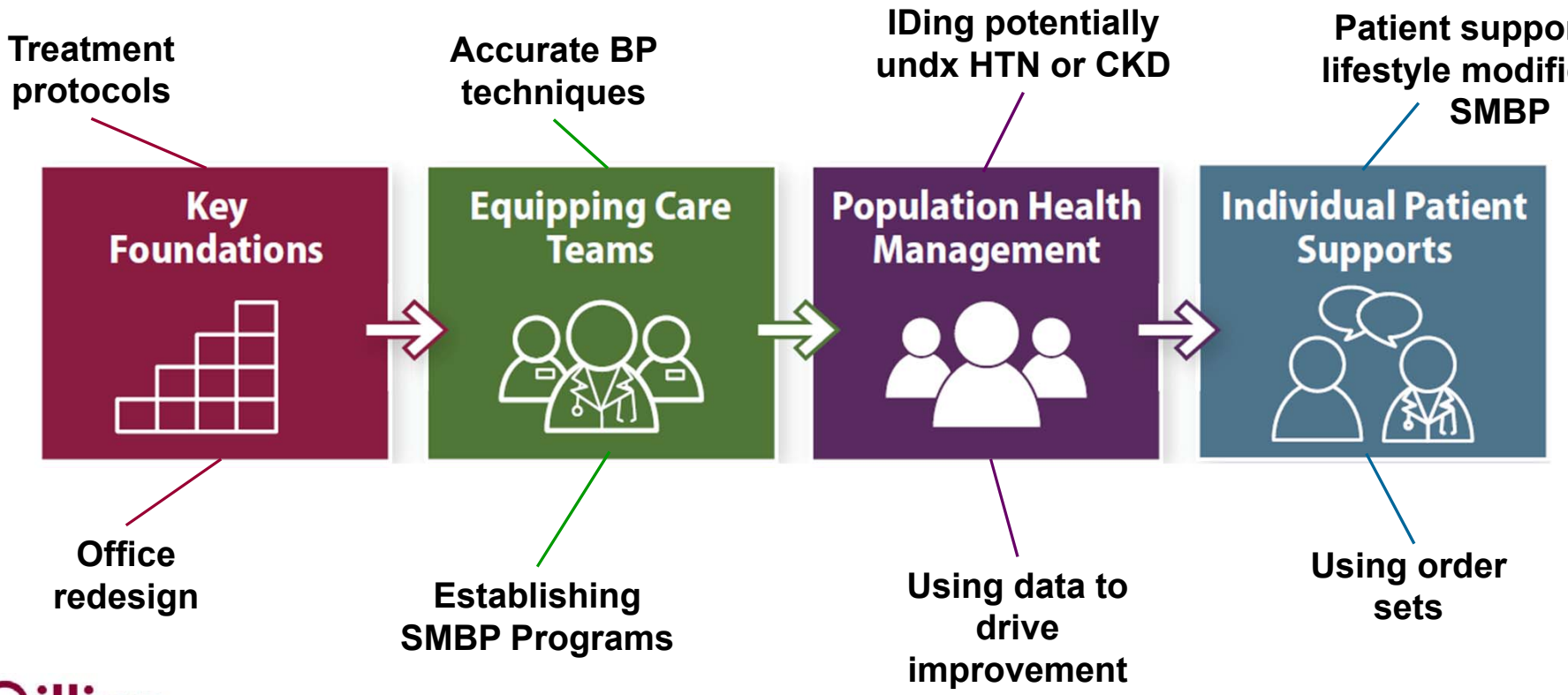
Change Concept	Change Idea	Tools and Resources
Implement a Policy or Process to Address BP for Every Patient with HTN at Every Visit	Manage resi	• NYC Health & Hospitals — Adult Hypertension Clinical Practice Guidelines: Treatment of Resistant Hypertension • **Zufall Health** — Guidelines for Screening, Diagnosis and Management of Hypertension (pp. 12–13) • Resistant Hypertension: Detection, Evaluation, and Management: A
	Evaluate all with HTN fo diagnose an if appropriat	

Table 2. Equipping Care Teams

Change Concept	Change Idea	Tools and Resources
Train and Evaluate Direct Care Staff on Accurate BP Measurement and Documenting	Adopt a clinician/staff training policy to train and retrain staff	• AMGF — Measure Up Pressure Down Provider Toolkit to Improve Hypertension Control: Plank 1, Tool 9: Blood Pressure Champion and CDS Education and Auditing Process for New Staff, **HealthPartners**
	Provide guidance on measuring BP accurately	• **Cheshire Medical Center/Dartmouth-Hitchcock** — Obtaining Accurate Blood Pressure Measurements in the Ambulatory Setting: How Do You Size a Blood Pressure Cuff? (pp. 14–19) • Target: BP — Blood Pressure Measurement: Measure Accurately • Target: BP — 7 Simple Tips to Get an Accurate Blood Pressure Reading • AHA — The Importance of Measuring Blood Pressure Accurately Webinar [video] (CE credits) • AMGF — Measure Up Pressure Down Provider Toolkit to Improve Hypertension Control: Plank 1, Tool 11: Blood Pressure Accuracy and Variability Quick Reference, **HealthPartners** • AMGF — Measure Up Pressure Down Provider Toolkit to Improve Hypertension Control: Plank 1: Tool 7: How to Take Blood Pressure Properly [video] – How to Take Blood Pressure Properly: The Wrong Way, **Cornerstone Health Care** (now Wake Forest Baptist Health) [video] – How to Take Blood Pressure Properly: The Right Way, **Cornerstone Health Care** (now Wake Forest Baptist Health) [video] • AMGF — Measure Up Pressure Down Provider Toolkit to Improve Hypertension Control: Plank 1: Tool 14: Accurate Blood Pressure Measurement, **Premier Medical Associates** [video] • Table 8. Checklist for Accurate Measurement of BP. 2017 ACC/AHA Guideline for the Prevention, Detection, Evaluation, and Management of High

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

Focus Areas



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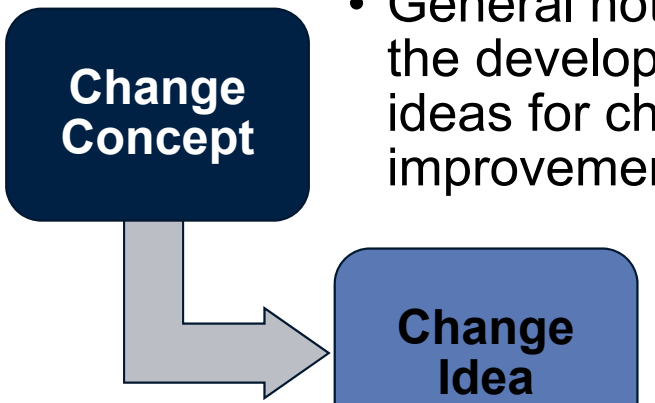
Change Package Format



- General notions that are useful in the development of more specific ideas for changes that lead to improvement
- Actionable, specific ideas for changing a process
- Can be adapted by or adopted in a health care setting

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Use Practice Data to Drive Improvement

Change Ideas

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

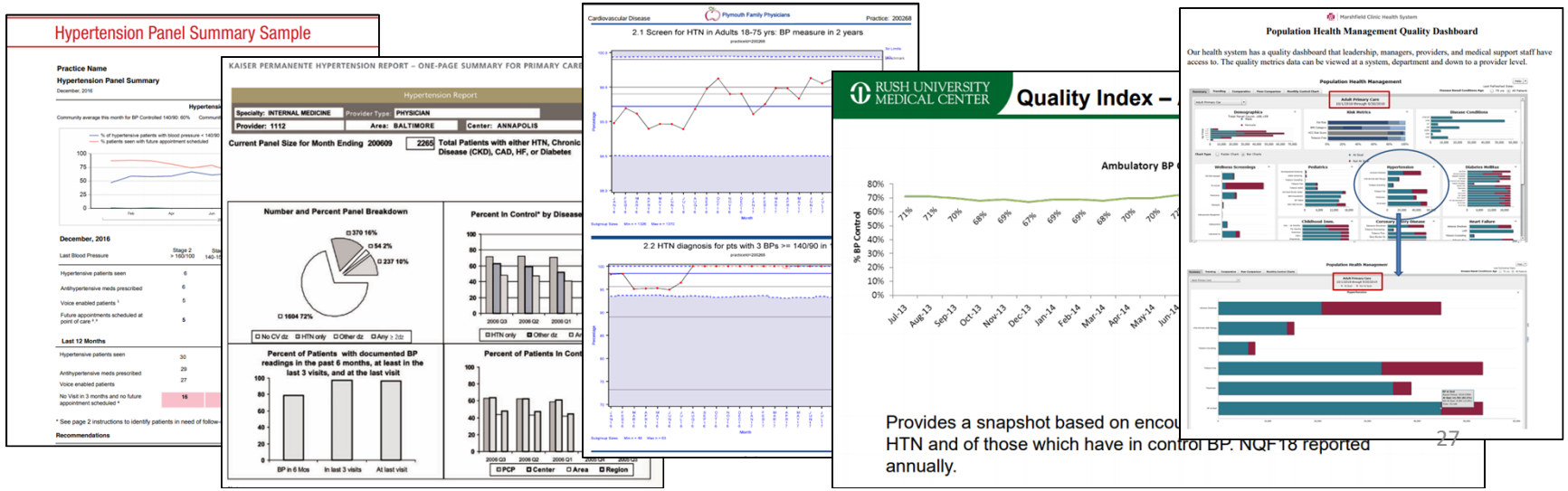
Use Practice Data to Drive Improvement

Change Ideas

Determine HTN control and related process metrics for the practice

Regularly provide a dashboard with BP goals, metrics, and performance

Tools & Resources



Key Tenants of Optimal Hypertension Management

- Accurate blood pressure measurement techniques
- Systematic use of hypertension treatment protocols
- Team-based care, especially with pharmacists, nurses, and community health workers
- Medication adherence strategies
- Self-measured blood pressure monitoring (SMBP) with clinical support
- Medication intensification workflows
- Patient engagement with ongoing clinical support and touch points
- Use of data to improve outcomes

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Other Hypertension Control Resources

- Million Hearts® Blood Pressure Control webpage
  https://millionhearts.hhs.gov/about-million-hearts/optimizing-care/bp-control.html
- Million Hearts® Learning Lab
  https://nachc.atlassian.net/wiki/spaces/MHLL/pages/1460405123/Million+Hearts+Learning+Lab
- Million Hearts® SMBP Forum
  https://nachc.atlassian.net/wiki/spaces/SMBP/overview
- NACHC Million Hearts® Initiative
  https://www.nachc.org/clinical-matters/nachc-million-hearts-initiative/

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Cardiac Rehabilitation

Description of Cardiac Rehabilitation (CR)

- **Comprehensive, medically-supervised, secondary prevention program**

- **Typically administered in 36 sessions over ~12 weeks to:**
  - Limit the effects of cardiac illness
  - Reduce the risk for sudden death or repeat cardiovascular event
  - Control cardiac symptoms
  - Stabilize or reverse the atherosclerotic process
  - Improve health and vocational status of patients

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Balady GJ, et al. Circulation. 2007;115:2675-2682.
Sandesara PB, et al. J Am Coll Cardiol. 2015; 65(4):389–95.

How is CR delivered?

- Typically delivered in an outpatient hospital setting
- Provided by a multidisciplinary team of professionals that may include:
  - Supervising clinicians
  - Exercise, physiologists and/or nurses
  - Pharmacists,
  - Nutritionists/dieticians, and
  - Psychosocial counselors
- Facilitates peer-to-peer sharing and social support

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Photo credit: https://www.uchealth.org/treatments-procedures/cardiac-rehab/, https://www.hopkinsmedicine.org/heart_vascular_institute/cardiology/cardiac-rehabilitation/; https://www.cdc.gov/heartdisease/cardiac_rehabilitation.htm

Who benefits from CR?

There is strong evidence of benefit for individuals who have:

- Had a heart attack
- Stable angina
- Received a stent or angioplasty
- Heart failure
- Undergone bypass, valve, or a heart, lung, or heart-lung transplant surgery

Amsterdam EA, et al. J Am Coll Cardiol. 2014;64(24):e139-e228.
O'Gara PT, et al. Circulati333333on. 2013;127(4):e362-e425.
Lawton, J.S., et al. Circulation. 2022;145(18):e895-e1032.
Sibilitz KL, Berg SK, Tang LH, et al. Cochrane Database Syst Rev. 2016;3:CD010876.
Rosenbaum AN, Kremers WK, Schirger JA, et al. Mayo Clin Proc. 2016;91(2):149-156.

Photo credit: https://www.cdc.gov/heartdisease/cardiac_rehabilitation.htm

CARDIAC REHABILITATION IS UNDERUSED

Cardiac Rehabilitation Enrollment, Engagement, and Completion Among Medicare Beneficiaries Aged 65 and Over

who had a primary qualifying event* in 2017:

29%
of patients initiated CR sessions

23%
of patients attended up to 12 sessions

17%
of patients attended up to 24 sessions

8%
of patients attended up to 36 sessions
(considered to be a full dose of CR)

Enrollment rates by sex:

3:2

number of **men vs. women** who initiated CR sessions.

Enrollment rates by race/ethnicity:

2:1

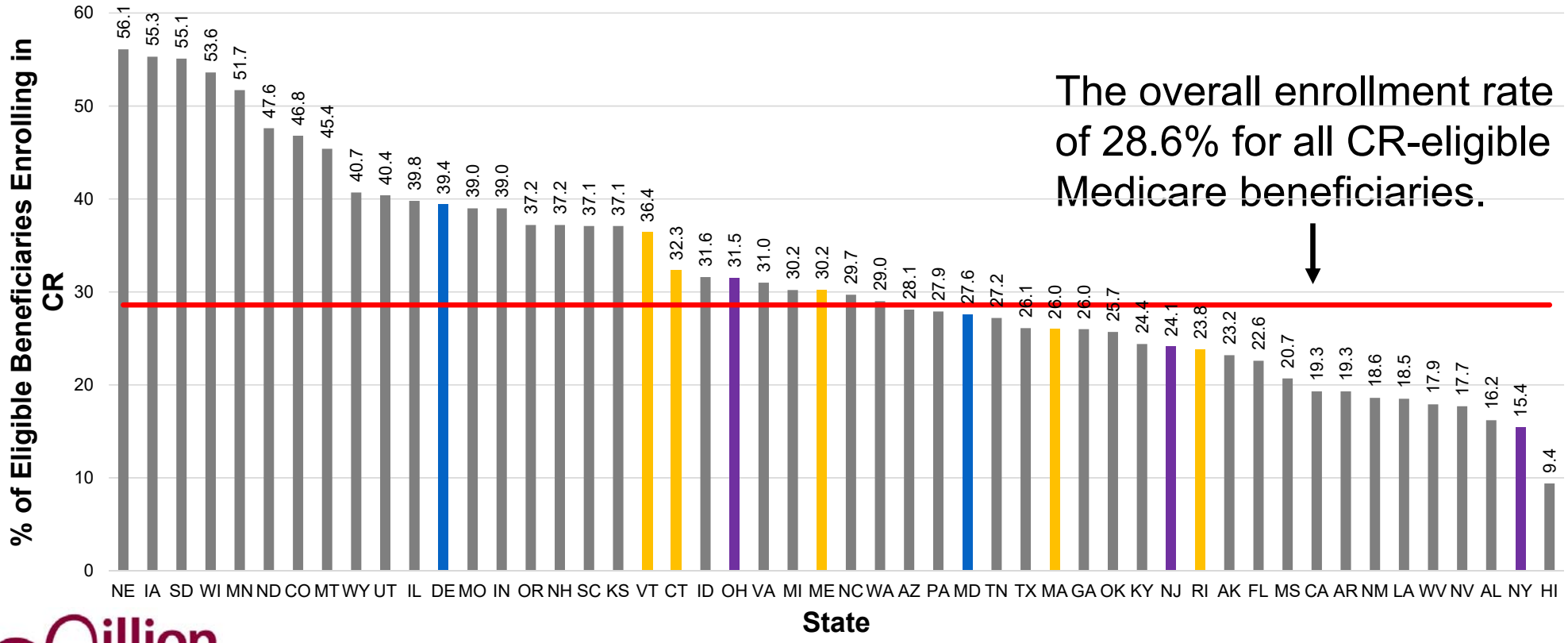
number of **non-Hispanic White vs. non-Hispanic Black people** who initiated CR sessions.

** hospitalization for acute myocardial infarction; coronary artery bypass graft surgery; heart valve repair or replacement; percutaneous coronary intervention; or heart or heart-lung transplant.*

Keteyian SJ, Jackson SL, Chang A, et al. Tracking Cardiac Rehabilitation Utilization in Medicare Beneficiaries: 2017 Update. *J Cardiopulm Rehabil Prev.* 2022;42(4):235-245.

https://millionhearts.hhs.gov/about-million-hearts/optimizing-care/cardiac-rehabilitation-infographic.html

CR Use Among Medicare Part B Fee-for-Service Beneficiaries by State



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= Qlarant

Keteyian SJ, et al.. *J Cardiopulm Rehabil Prev*. 2022;42(4):235-245.

Million Hearts®/AACVPR Cardiac Rehabilitation Change Package (CRCP)

- CDC-AACVPR collaboration
- Listing of process improvements with implementation tools and resources
- 105 tools and resources
- Expertise, tools, and resources from:
  - 18 states
  - 22 institutions
  - 36 CR professionals and researchers

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https://millionhearts.hhs.gov/files/Cardiac_Rehab_Change_Pkg.pdf

Cardiac Rehabilitation Change Package
Change Concepts

- Make CR a Health System Priority

- Incorporate Referral to CR into Hospital Standardized Processes of Care for Eligible Patients
- Standardize the CR Referral Process
- Use Data to Drive improvement in Referrals to CR

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Cardiac Rehabilitation Change Package
Change Concepts

- Educate Patients About the Benefits of Outpatient CR
- Reduce Delay from Discharge to First CR Appointment
- Use Data to Drive Improvement in Enrollment or Participation
- Reduce Cost-Sharing Barriers for CR Services
- Improve Efficiency of Enrollment
- Develop Flexible Models That Better Accommodate Patient Needs
- Modify Some Program Procedures Based on Clinical Need
- Use Clinician Follow-up to Bolster Enrollment or Participation

- Identify Populations at Risk for Low Engagement
- Improve Patient Engagement

Million Hearts®/AACVPR Cardiac Rehabilitation Change Package, 2nd Edition

- **What's new:**
  - Making the business case for CR
  - CR program staffing models
  - More tools for implementing automatic referrals with care coordination
  - Strategies to build equity in CR enrollment
  - New tools for hybrid CR programs
  - Strategies to increase CR participation among people with qualifying heart failure

https://millionhearts.hhs.gov/tools-protocols/action-guides/cardiac-change-package/index.html

Million Hearts® Cardiac Rehabilitation Portfolio

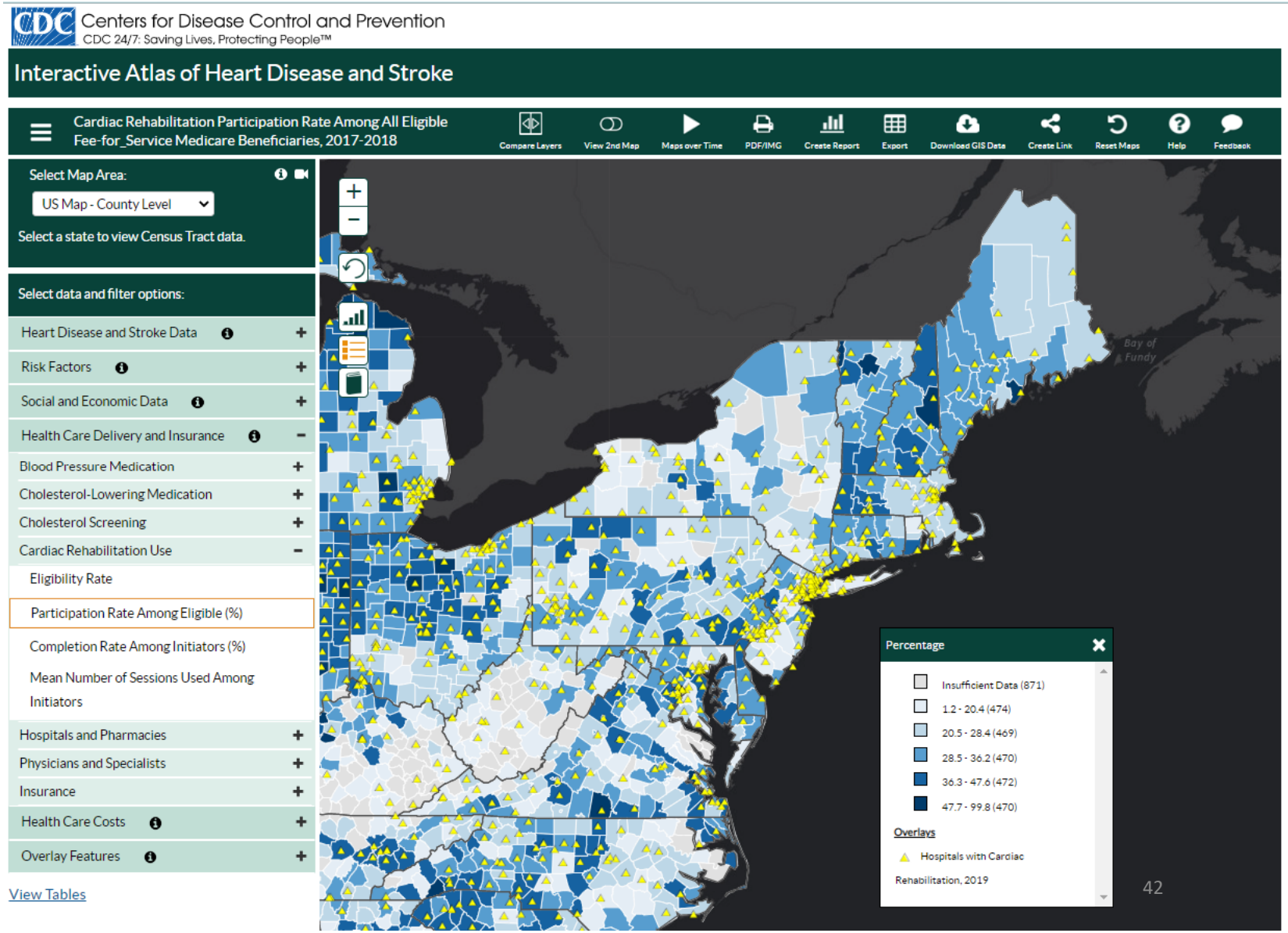
1. **Establish and nurture partnerships**
   - → Million Hearts® Cardiac Rehabilitation Collaborative
2. **Develop and maintain national CR surveillance**
3. **Support and engage state and local partners**
   - →Innovative State and Local Public Health Strategies (CDC-RFA-DP18-1817) – ends Sept 2023
   - →Million Hearts® Hospitals & Health Systems Recognition Program
   - →Engagement with AACVPR State Affiliates, ACC Chapters, QIN/QIOs, payers, and other state or regional partners
4. **Advance development, validation, and adoption of new CR delivery models**
   - → Publications from the Million Hearts® CR Think Tank
5. **Amplify key messages about CR and strategies to equitably increase CR participation**

Million Hearts® Cardiac Rehabilitation Collaborative (CRC)

- **Aim:** 70% CR participation (among those eligible)
- **Focus:** strategies in the annual CRC Action Plan
- **Convenes quarterly to:**
  - Disseminate new information and resources
  - Highlight opportunities for engagement
  - Facilitate collaboration across local, state, and national public and private partners
  - Recognize top contributors and celebrate achievements
  - Increase access to national and international subject matter experts

https://millionhearts.hhs.gov/about-million-hearts/optimizing-care/cardiac-rehabilitation-CRC.html

CDC's Interactive Atlas of Heart Disease and Stroke Prevention
https://www.cdc.gov/dhdsp/maps/atlas/index.htm



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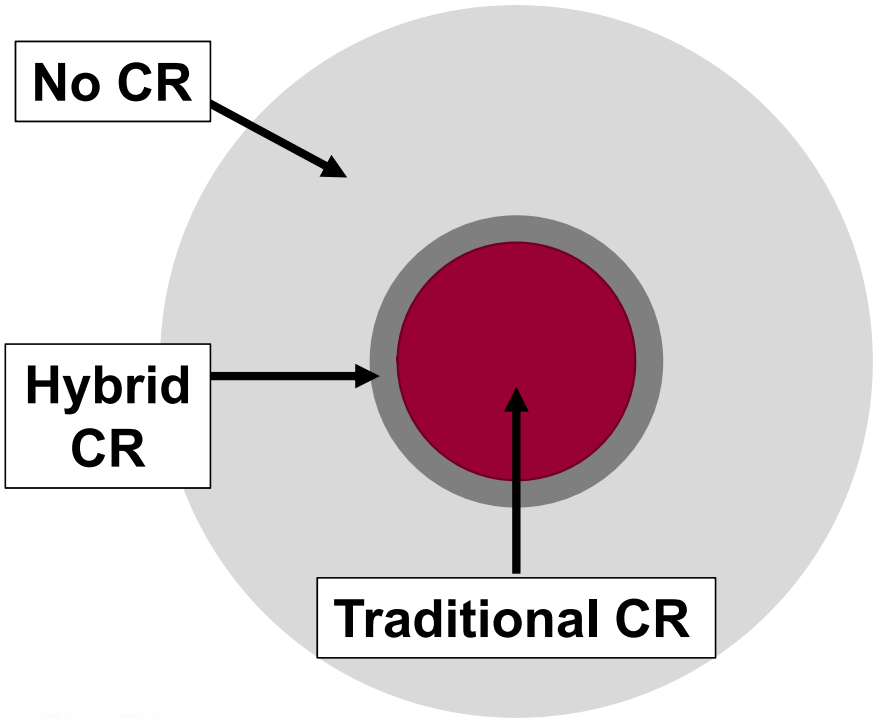
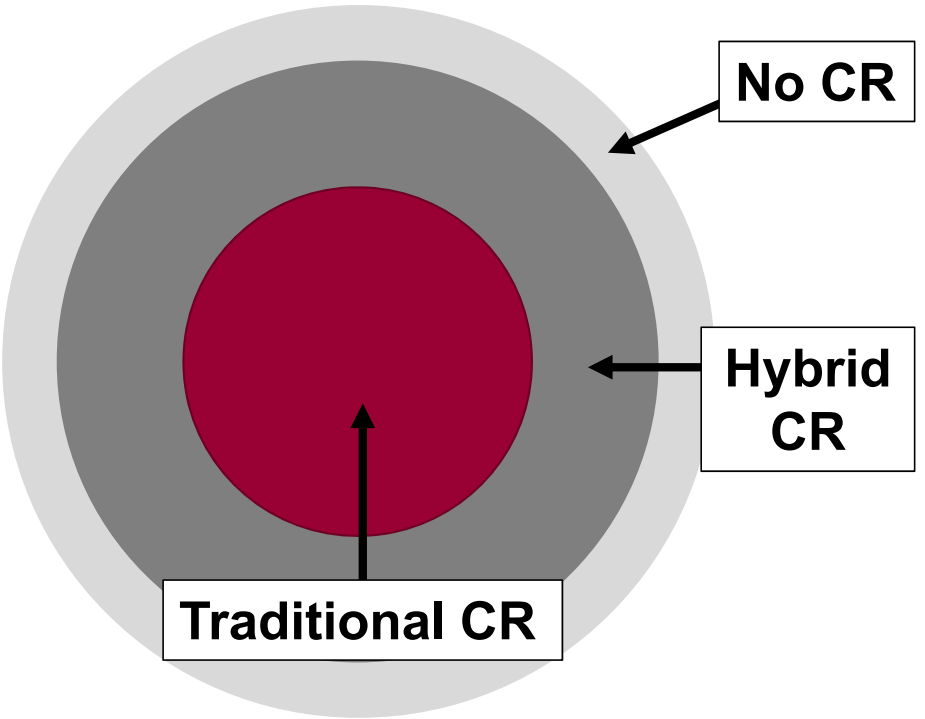
New Paradigm to Optimize Use of Cardiac Rehabilitation



Old Paradigm
(current model)



New Paradigm
(new model)

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Adapted from Olson, T. Balancing Technology with the Human Touch to Promote Exercise is Medicine. AACVPR 2018

2020 Million Hearts® CR Think Tank for Advancing New Care Models

Terminology

Evolving to reflect not *where* CR delivered, but *how*:

- In-person synchronous
- Virtual synchronous
- Remote asynchronous

Core Components

Multidisciplinary components of CR must be preserved:

- Exercise training
- Nutrition counseling
- Risk factor management
- Psychosocial management

Policy

- Public health emergency waivers allow virtual synchronous CR.
- Policy changes will be needed to reimburse new models in the future.

Equity

The following strategies may improve equity:

- Leverage community resources
- Medicaid coverage for new models
- Reduce financial barriers

Implementation

- Stable patients can exercise with low risk of complication.
- Exercise prescription should progress to 150 minutes/week of moderate exercise.
- Education resources are available.

Research

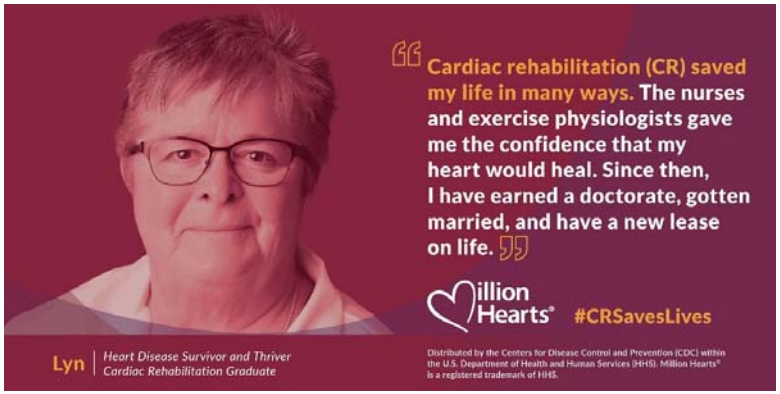
Evidence gaps include:

- Under-represented populations
- Patient-centered outcomes
- Effects on long-term outcomes and cost
- Implementation in diverse settings

- Beatty A, et al. Million Hearts Cardiac Rehabilitation Think Tank: Accelerating New Care Models. Circ: Circ Cardiovasc Qual Outcomes. 2021;14:e008215.
- Keteyian SJ, et al. A Review of the Design and Implementation of a Hybrid Cardiac Rehabilitation Program: An Expanding Opportunity For Optimizing Cardiovascular Care. J Cardiopulm Rehabil Prev. 2022 Jan 1;42(1):1-9.
- Beatty AL, et al. A New Era in Cardiac Rehabilitation Delivery: Research Gaps, Questions, Strategies, and Priorities. Circulation. 2023 Jan 17;147(3):254-266.

Million Hearts® Communication Resources

- Cardiac Rehabilitation Webpage
  → Available for syndication here
- Cardiac Rehabilitation Communications Toolkit
- Cardiac Rehabilitation Collaborative
  → Register to join our Q1 CRC meeting on Feb 23: https://cdc.zoomgov.com/meeting/register/vJIscO6prTouGfqHIO574G4Hwm7RSTSTg9s
- Facebook, Twitter, and LinkedIn
  → #CardiacRehab and/or #CRSavesLives



Opportunities for Engagement

SPAN, HOP, and REACH NOFOs

- CDC-RFA-DP23-2312: The State Physical Activity and Nutrition Program (SPAN) (https://www.grants.gov/web/grants/view-opportunity.html?oppId=342954)
- CDC-RFA-DP23-2313: The High Obesity Program (HOP) (https://www.grants.gov/web/grants/view-opportunity.html?oppId=342939)
- CDC-RFA-DP23-2314: Racial and Ethnic Approaches to Community Health (REACH) (https://www.grants.gov/web/grants/view-opportunity.html?oppId=342940)

	Post Date	Application Due	Estimated Award Date	Estimated Project Start
HOP	Jan 18, 2023	March 21, 2023	Aug 30, 2023	Sept 30, 2023
SPAN	Jan 27, 2023	March 28, 2023	Aug 30, 2023	Sept 30, 2023
REACH	Feb 8, 2023	April 11, 2023	Aug 30, 2023	Sept 30, 2023

2023 Million Hearts® Hypertension Control Challenge

- Apply to be a 2023 Hypertension Control Champion: **Feb 27 – Apr 14, 2023**
- **≥ 80%** blood pressure control
- **Apply at:** millionhearts.hhs.gov

Million Hearts®

Remaining states without a Champion: AL, AR, ID, ME, NC, NV, SD, and VT

Million Hearts® Campaigns

Start Small. Live Big

Encourages adults 55 and older, to get back on track with the small steps—like scheduling their medical appointments, getting active, and eating healthy—so they can get back to living big.

Live to the Beat

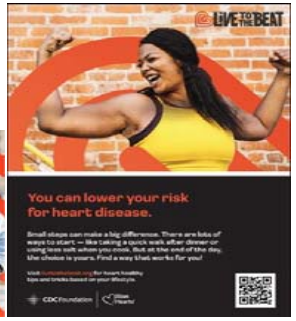
Empowering Black adults to pursue heart-healthy lifestyles – prevention focused.

Million Hearts®

“Live to the Beat” Campaign Resources

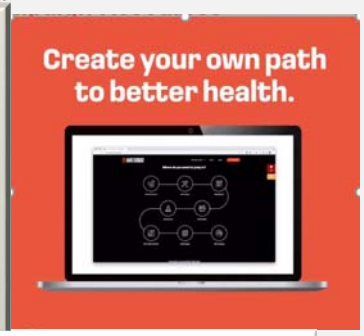
PROMOTIONAL CONTENT

- **“Right Ways” Video PSAs** *(:15, :30 and :60)*
- **“On Rhythm” Video PSAs** *(:15, :30 and :60)* - ***NEW***
- **“Your Beat” Radio :30 PSAs**
- **Social Media Graphics/Ads/Gifs – *NEW***
- **Campaign Flyers**
- **Campaign Posters**
- **Campaign Postcards – *NEW***
- **“Stories from the Heart” Gifs – *NEW***



EDUCATIONAL RESOURCES

- **Live to the Beat with KevOnStage – *NEW***
  7-episode web series tackling heart-healthy topics with humor
- **Pulse Check Roadmap – *NEW***
  Interactive small steps roadmap with quizzes & short content
- **Animated Educational :60 Videos – *NEW***
  Animated explanations of how/why risk factors and prevention strategies affect your CVD risk



PROMOTIONAL GIFTS

(Limited Supply)

- **Small Steps Tracker Magnets**
- **Adjustable Measuring Spoons**
- **Cooling Towels**
- **Aprons**
- **Water Bottles**
- **T-Shirts**
- **Bento Lunch Boxes**
- **Cordless Jump Ropes**

Ambassador Opportunities

LIVE TO THE BEAT

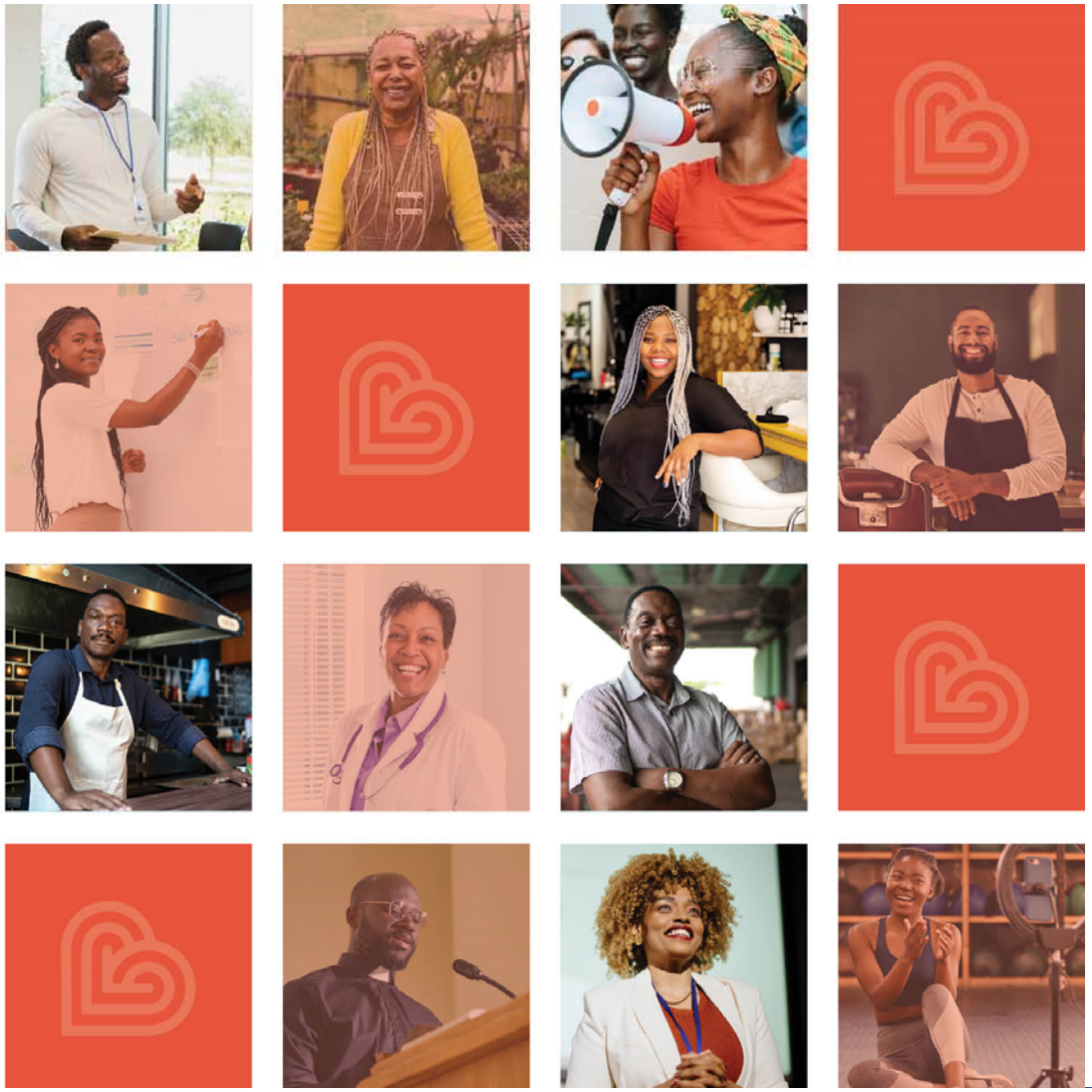
Community Ambassador Network

The CDC Foundation and Million Hearts® invite you

to join an exclusive network of trusted leaders, organizations, and businesses in the Black community to help us empower more adults to live their healthiest lives. As a **"Live to the Beat" Community Ambassador**, you can help those in your community lower their risk for heart disease and stroke. As an Ambassador, you would:

- **Share heart-healthy messages and resources with your community.**
- **Promote sweepstakes where your audiences can win cool prizes for taking healthy steps.**
- **Gain national recognition and a chance to earn prizes of your own.**

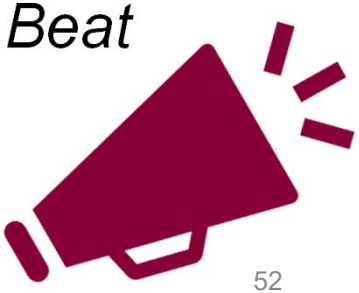
Visit **bit.ly/communityambassadorsnetwork** to express interest.



How Can You Get Engaged?

- **Use or share** the Hypertension Control Change Package or Cardiac Rehabilitation Change Package
- **Join our learning collaboratives** (i.e., Million Hearts® Learning Lab, SMBP Forum, and/or the Million Hearts® Cardiac Rehabilitation Collaborative)
- **Amplify messages** about the Million Hearts® 2023 Hypertension Control Challenge (especially in Maine and Vermont)
- **Promote opportunities to engage** with the *Live to the Beat* campaign

Million Hearts®



Thank You

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MillionHearts@cdc.gov

Focus on Health Equity

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Disparities

Hypertension

- Black adults (56%) are more likely to have high blood pressure compared to white adults (48%), Asian adults (46%), or Hispanic adults (39%)
- Black people are also more likely to develop high blood pressure earlier in life, compared to White people
- Economic disparities, racism, medical mistrust, lack of access, and other structural inequities are all contributing factors

Cardiac Rehab

- Probability of attending CR is 31% lower for Asian individuals, 19% lower for Black individuals and 43% lower for Hispanic individuals compared to White individuals
- Compared to White individuals, the time to attendance in the first CR session averaged 9 days longer for Asian and Black people and 10 days longer for Hispanic people

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Strategies to Address these Disparities

- Screening and addressing social drivers of health
  - Food access, transportation, housing, employment, health insurance
- Using Shared Decision-Making tools
- Person-centered and culturally-informed communication
  - CLAS standards, health literacy considerations
- Building connections with trusted community-based organizations
  - Barbershops and salons, community centers, faith organizations

What successes or challenges are you having on advancing health equity for heart health in your organization?

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Resources

Hypertension – for Patients

- LINKS Portfolio: https://qi-library.ipro.org/2023/02/07/hypertension-links-portfolio/
- https://qi-library.ipro.org/2023/01/19/how-to-measure-your-blood-pressure/
- https://qi-library.ipro.org/2023/01/31/what-you-need-to-know-about-managing-your-cholesterol/

Cardiac Rehab – for Providers & Patients

- Implementation Guide: https://qi-library.ipro.org/2023/01/31/cardiac-rehabilitation-implementation-guide-to-enhance-patient-referrals-engagement/
- New England CR Program List: https://qi-library.ipro.org/2023/01/31/cardiac-rehabilitation-programs-in-new-england/

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Hypertension Portfolio

LINKS (Local Interactive Network of Knowledge Sharers) Education Materials and Guidance

The IPRO QIN-QIO has prepared educational materials to help spread awareness about health topics relevant to your community members and to support population health. Each LINKS portfolio introduces a health-related topic and resources for more information. Our goal is to help organizations like yours start the conversation with your community members.

This LINKS portfolio focuses on hypertension prevention and management. As with all IPRO QIN-QIO LINKS portfolios, materials are designed for consumers/patients/residents and can be tailored to fit the needs of your specific audience or community.

Resources

The following educational materials, available on the IPRO QIN-QIO resource library, are intended to be adopted/adapted and shared in order to increase awareness about hypertension and enhance the health of your community.

- PowerPoint slide presentation: Hypertension: Staying Healthy through Prevention and Self-Management
- Hypertension Fact Sheet: What is Hypertension, and What You Can Do
- Cholesterol Fact Sheet
- Infographic: How to Measure Your Blood Pressure: https://qi-library.ipro.org/2022/07/27/how-to-measure-your-blood-pressure

Using the LINKS Resources

These materials are designed for a lay audience of community members. The following are suggestions for distributing or presenting the LINKS resources:

- PowerPoint slides may be presented at local community or senior centers, assisted living facilities, supportive housing sites, congregate dining sites, community health centers/federally qualified health centers, and other community locations. The slides can be adapted to fit your organization's needs and audience. The presentation might also be useful in providing educational information to consumers remotely/virtually.
- The fact sheets and info graphics can be posted on your organization's website and social media platforms to build awareness, especially during Heart Health Month (February). aper copies could be distributed during home-delivered meal visits or case management visits, or at community centers similar to the above list.

Measuring Reach & Impact

- Each trainer should track number of presentations/sessions provided (for presentations) and the number of participants/attendees
- A short survey/questionnaire for participants can help assess their knowledge and collect any feedback. Suggestions for survey questions:
  - What did you like most about the hypertension learning event?
  - What do you now know about hypertension that you did not know before? Did today's session provide helpful information to help you manage your health? If not, please tell us more:
  - Please share one thing you plan to do to help improve your overall health (examples for multiple choice: exercise more often, monitor my blood pressure at home, reduce salt in my diet, etc.)
  - What other health education events would be helpful for you?

The IPRO QIN-QIO is available to help support you. We can set up online data capture tools to help assess your reach and impact.

Additional Resources and Support

- Please contact us with any questions: https://qi.ipro.org/contact-us
- LINKS materials and other resources can all be found on the **IPRO QIN-QIO Resource Library**: https://qi-library.ipro.org
- Looking for more information or want to connect with other community partners? **Join the LINKS Facebook page:** https://www.facebook.com/groups/iprolinks

Hypertension: What You Need to Know

What is Hypertension?

Hypertension, or high blood pressure, means that the pressure in your blood vessels is higher than it should be. Blood pressure is the force of blood pushing against blood vessel walls and is measured in millimeters of mercury, or mm Hg. When measured, blood pressure is recorded as two numbers, like 120/80 mm Hg. The larger number is systolic pressure, or pressure when the heart beats, and the smaller number is diastolic pressure, or pressure when the heart rests between beats. A healthy blood pressure is at 120/80 mm Hg or below for adults. As the numbers rise, blood pressure can move from elevated, to high, to a hypertensive crisis.

https://qrco.de/bdewLG

Why It Matters

Nearly half of American adults have high blood pressure, which increases their risk for heart disease, stroke and other serious conditions. High blood pressure usually has no obvious signs or symptoms. This is why blood pressure is measured during most clinical visits, so any elevations can be detected and treated early. Age, gender, family medical history, diet, race and ethnicity, and other chronic conditions like sleep apnea or chronic kidney disease, are all factors that can increase the risk of developing high blood

What You Can Do

Fortunately, there are some things you can do to help prevent or manage high blood pressure. Here are some things to consider:

Monitor your Blood Pressure: Adults aged 40 and older should get their blood pressure checked once a year. Your doctor might recommend screening more often based on your overall health. https://qrco.de/bdewMX

You can measure your blood pressure at home using an automatic blood pressure cuff, or your local pharmacy or grocery store may have an automatic blood pressure cuff available for public use. Documenting your numbers and the date is helpful for tracking any changes and keeping your primary care provider informed.

For more tips: **How to measure your blood pressure:** https://qrco.de/bdewNA

BLOOD PRESSURE CATEGORY	SYSTOLIC mm Hg (upper number)		DIASTOLIC mm Hg (lower number)
NORMAL	LESS THAN 120	and	LESS THAN 80
ELEVATED	120–129	and	LESS THAN 80
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 1	130–139	or	80–89
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 2	140 OR HIGHER	or	90 OR HIGHER
HYPERTENSIVE CRISIS (consult your doctor immediately)	HIGHER THAN 180	and/or	HIGHER THAN 120

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Additional Resources

- PRAPARE Tool – IPRO QIN-QIO Resource Library
- Social Determinants of Health (SDoH) – A Guide for Getting Started – IPRO QIN-QIO Resource Library
- A Guide To Screening Patients for Food Insecurity – IPRO QIN-QIO Resource Library
- Decision Worksheets | MGH Health Decision Sciences Center (mghdecisionsciences.org)
- Health Equity: Resources – IPRO NQIIC (qi-ipro.tempurl.host)

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Mark Your Calendar for Upcoming Sessions

Partnering Beyond COVID-19 Prevention and Management of Patients with Chronic Disease

- **March 15th** Learning Circle: Heart Health
- **March 29th** Kidney Health: CKD
- **April 12th** Diabetes
- **April 26th** Learning Circle: Diabetes/Kidney Health
- **May 10th** Cardiac Rehab
- **May 24th** The Role of Nutrition

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Let Us Know More…

Your feedback is critically important and will help guide us as we prepare future educational sessions for you.

Please take just a few minutes to complete our brief evaluation that will be sent out after this session. Thank you!

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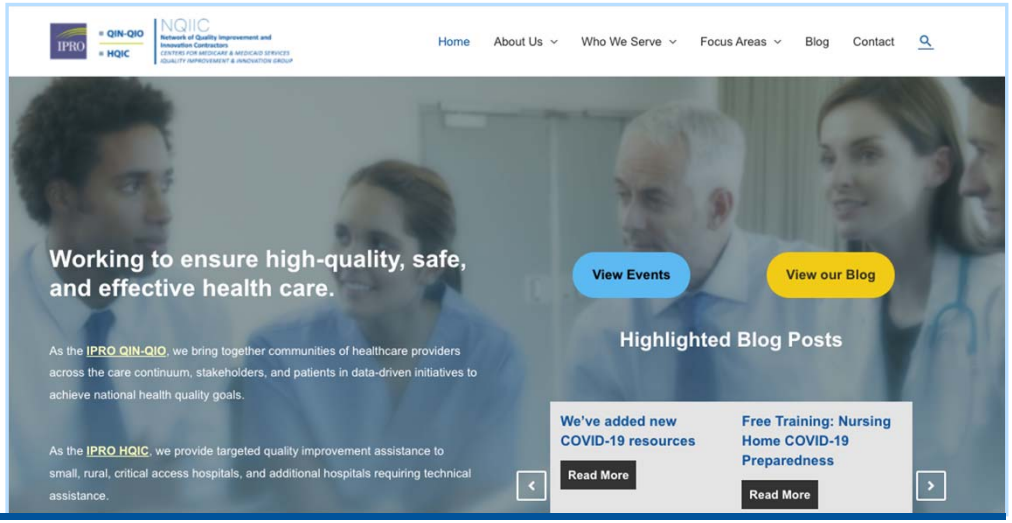

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Thank You

Thank you for your continued partnership and commitment to quality improvement.