National Hypertension Control Roundtable

Annual Meeting Minutes

September 20 - 21, 2021

PREPARED FOR

CDC Foundation

PREPARED BY

commonality

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Overview & Agenda Synopsis

The National Hypertension Control Roundtable (NHCR) is a coalition of public, private, and voluntary organizations, and invited individuals dedicated to eliminating disparities in hypertension control through dialogue, partnership, evidence and innovation. Founded in 2020, NHCR meets with its membership annually to assess the current state of hypertension control nationally, reconfirm the coalition's collective goals, and strategize for the future. NHCR's 2021 Annual Meeting (hereafter referred to as "the meeting") took place virtually on September 20 and 21, 2021, in pursuit of the following three objectives:

Summit Objectives

1. Define how the NHCR can leverage its collective knowledge, resources, and assets to reduce disparities in hypertension control.
2. Introduce the NHCR's new guiding principles and multi-year Strategic Framework.
3. Refine strategies for collective action to advance the objectives of the new Strategic Framework, establish organizational Action Teams, and help realize the NHCR's vision for the future.

To achieve the meeting's objectives, the meeting planning committee - composed of representatives from the NHCR's Steering Committee and Leadership team, and facilitators from Commonality, Inc. - designed a two-day, six-hour virtual meeting featuring a variety of roundtable conversations, large group discussions, short didactic "burst" presentations, and small group breakout exercises. These sessions collectively highlighted the critical role that multi-sector collaboration can play in helping to equitably achieve hypertension control nationally, and included:

Day One:

- A warm welcome outlining the the goals and objectives of the two-day meeting
- An introduction to the new NHCR Strategic Framework and a discussion of the ways in which it purposefully aligns with the goals of the *2020 Surgeon General's Call to Action to Control Hypertension*
- A presentation underscoring the disparities in hypertension control across the United States, and the importance of ensuring an equity lens in NHCR's work
- A discussion on the the powerful impact partnerships between the healthcare sector and local organizations can make in advancing hypertension control in communities nationwide

Day Two:

- A roundtable conversation on the the systems-changes needed to successfully address hypertension control across the country
- Micro-burst presentations on the importance of pursuing policy approaches to advance hypertension control in various settings

Each day participants additionally had the opportunity to participate in small group breakout sessions designed to support the work of three Action Teams that the NHCR plans to launch following the meeting. The meeting featured presentations and remarks from the following individuals:

Meeting Presenters

- Katie Adamson | Vice President, Health Partnerships and Policy, YMCA of the USA
- Mary Ann Bauman, MD | President, Western States Region Board, American Heart Association
- Anne Burns, BSPharm, RPh | VP Professional Affairs, American Pharmacists Association
- Don Casey, MD, MPH, MBA | Associate Professor of Medicine, Rush Medical College
- Hae Mi Choe, PharmD | Associate Chief Quality & Innovations Officer, University of Michigan Medical Group
- John Clymer | Executive Director, National Forum for Heart Disease & Stroke Prevention
- Yvonne Commodore-Mensah, PHD, MHS, RN | Assistant Professor, Johns Hopkins Schools of Nursing and Johns Hopkins Bloomberg School of Public Health/Preventive Cardiovascular Nurses Association
- Keith C. Ferdinand, MD, FACC, FAHA, FNLA, FASPC | Professor of Medicine, Tulane University School of Medicine
- Scott Flinn, MD | Regional Medical Director, Blue Shield of California
- Marti Macchi, MEd, MPH | Senior Director of Programs, National Association of Chronic Disease Directors
- Modele Ogunniyi, MD | Associate Professor of Medicine, Emory University/ Association of Black Cardiologists
- Lisa D. Sanders, MHA | State Regulatory Advisor, American Heart Association
- Denise Octavia Smith, CHW, PN, MBA | Executive Director, National Association of Community Health Workers
- Eduardo Sanchez, MD, MPH | Chief Medical Officer for Prevention, American Heart Association
- Janet Wright, MD I Director, Division for Heart Disease and Stroke Prevention, Centers for Disease Control and Prevention (CDC)

The following pages feature the minutes from the meeting, including details on the key learnings and next steps that emerged during the meeting's proceedings.

Day One

Welcome Remarks

The first day of the meeting commenced with remarks from the Centers for Disease Control and Prevention's (CDC) Janet Wright, MD, the American Heart Association's (AHA) Eduardo Sanchez, MD, MPH, and the National Forum for Heart Disease & Stroke Prevention's John Clymer. In their presentations, each speaker sought to warmly welcome participants to the meeting, discuss the value of the NHCR's mission and vision, and set the stage for the agenda ahead:

- Dr. Wright discussed the critical importance of the NHCR's work, and shared her hopes for the impact that will be made via the NHCR's prioritization of powerful strategies to improve blood pressure control, reduce health disparities and achieve health equity in the nation.
- Dr. Sanchez stressed the importance of collaboration, noting the essential value of community-based connections and partnerships in achieving the ultimate goal of blood pressure control. Dr. Sanchez also highlighted the strengths of the coalition, thanked the Steering Committee for their leadership and guidance, and introduced the NHCR's new guiding principles.
- Mr. Clymer presented a draft of the NHCR's new Strategic Framework. Developed (in tandem with the new guiding principles) over the last six months via member focus group input and Steering Committee workshops, the Strategic Framework will direct the work of the NHCR's membership over years to come.

Keynote: Effective Strategies to Equitably Advance Hypertension Control

For the keynote address, NHCR invited Keith Ferdinand, MD, FACC, FAHA, FNLA, FASPC, Professor of Medicine at Tulane University School of Medicine, to present. Dr. Ferdinand focused his presentation on the dire health inequities present in hypertension nationally, as well as the strategies needed to achieve blood pressure control and eliminate disparities. The key points from his presentation include:

- Health inequities are associated with hypertension:
    - Hypertension, especially in Black adults, increases morbidity and mortality and leads to diminished longevity.

    - Disparities are impacted by lifestyle, socioeconomic status, environment and structural inequalities.
- To make real change, society must address unacceptable, longstanding disparities in hypertension and cardiovascular disease:
    - Therapeutic lifestyle changes, patient education, and pharmacotherapy are necessary to reduce disparities and support healthy blood pressure for all.
    - Self-monitored blood pressure (SMBP) and combination therapy with algorithms have been proven to improve hypertension control, and are vital tools for the nation.
    - Community-based interventions, such as the Barbershop Program, can also make a powerful impact at the local level.

Dr. Ferdinand concluded his presentation by sharing key considerations for NHCR to reflect upon as it strategizes for the future, noting much impact might be made by:

- Ensuring that all individuals nationwide have adequate insurance and an identifiable source of primary care.
- Removing barriers to care (with specific emphasis on removing copays for generic medication).
- Ensuring patient advocacy groups and community activists have a seat at the table and are recruited to join the NHCR.

Following Dr. Ferdinand's presentation, a question and answer (Q & A) discussion took place. Several topics were addressed, including:

- Electronic Health Records (EHR), and how quality measures embedded in EHR systems, as well as the tracking of social determinants of health, might help move the needle on hypertension.
- The ways in which pharmacists, advanced practice nurse practitioners and physician assistants can help community members manage their blood pressure locally.
- The critical fact that providers and systems of care must be more sensitive to the impact of race in their policies and practices.
- The need for Medicaid expansion: counties which expanded Medicaid have had less cardiovascular mortality than counties that did not expand Medicaid.
- The impact of zip codes on outcomes: providers in zip codes with many resources are more likely to have better outcomes/may appear to provide higher quality care, vs. providers in zip codes with fewer resources are more likely to have worse outcomes/appear to offer lower quality care.

Roundtable: Bridging Communities and Healthcare to Increase Hypertension Control

The second session of the day featured a panel discussion about bridging communities and healthcare to increase hypertension control. The panel was moderated by Yvonne Commodore-Mensah, PhD, MHS, RN, from the Johns Hopkins School of Nursing, Bloomberg School of Public Health, and the Preventive Cardiovascular Nurses Association, and featured Katie Adamson of the YMCA of the USA, Denise Octavia Smith, CHW, PN, MBA, of the Association of Community Health Workers, and Hae Mi Choe, PharmD, from the University of Michigan Medical Group. The conversation addressed many subjects, including:

- An overview of the panelists' evidence-based programs related to hypertension control
- The effectiveness of community health workers, health educators within community organizations, and pharmacists in helping to control hypertension in communities
- The ways in which pairing pharmacists with primary care providers in health systems (including sharing EHR access) can support hypertension control
- How shifting from a fee-for-service model to value-based care might move the needle for blood pressure control
- A recommended reimbursement payment model to support the work of pharmacists
- The need to advocate for community-based program reimbursement

Following the roundtable, a brief Q&A took place. The main topics addressed included ways to scale the facilitation of connections within communities, and the necessity of ensuring a broad array of clinicians and allied health professionals work as a team in a community to support hypertension control.

NHCR Strategic Framework Small Group Discussion - Part One

For the final session of the day, NHCR participants were separated into three small breakout groups moderated by the meeting facilitators from Commonality, Inc. Each group was asked to review one of three objectives from the NHCR Strategic Framework, and share thoughts regarding what an Action Team dedicated to advancing that specific objective might need to achieve success. The three objectives discussed were:

- Foster partnerships to support population-level control of hypertension
- Amplify and advance effective hypertension control programs and practices to improve clinical and community systems
- Catalyze funding and payment systems to advance equitable hypertension control

The notes for each breakout session can be found in Appendix A.

Day Two

Panel: Implementing Systems-based Approaches to Hypertension Management

The second day of the meeting commenced with a panel discussion centered on the healthcare systems-based approaches needed to successfully achieve hypertension management. Moderated by AHA's Dr. Eduardo Sanchez, the panel featured Don Casey, MD, MPH, MBA, from Rush Medical College, Scott Flinn, MD, from Blue Shield of California, and Mary Ann Bauman, MD, from AHA. A variety of topics were tackled by the panel, including:

- Barriers to implementing proven hypertension management strategies in healthcare settings, including provider inertia, a lack of consensus on blood pressure staging and control levels, a need for continuous measurement and personalized care, public awareness of the issue's urgency, the lack of adequate capital (social, political, economic) to elevate this challenge, and the need for coordination between systems and clinicians/allied health care professionals.
- The many ways in which systems of care should change to address the barriers discussed, including ensuring health care organizations commit to/hold themselves accountable for hypertension control care and making the business case for blood pressure control/identifying incentives for its advancement.
- Effective strategies for addressing social needs in clinical care, including advocating for the inclusion of community health workers and social workers in care, meeting individuals where they are with what they need to access care (e.g., transportation, access to healthier foods), and resolving the digital divide to provide equitable access to mHealth solutions.
- The *Blueprint for Change: Defining and Promoting a Single, Effective System of Care for Patients with High Blood Pressure*, and the role it might play in advancing the health care system toward achieving hypertension control.
- Best practices for care, including the importance of tracking hypertension via registries to ensure blood pressure is measured consistently and accurately, and improving medical coding processes (e.g., z codes) so that such tracking is more efficient and so social determinants of health are better reflected to advance the provision of personalized care.
- The role NHCR can play in making hypertension control a national priority.

Policy Approaches to Hypertension Management

The second session of the day focused around policy approaches to hypertension management. This session featured two micro-burst presentations: one from Anne Burns, BSPharm, RPh from the American Pharmacists Association, and one from Lisa Sanders, MHA, from the AHA. The two presentations collectively addressed several critical topics related to policy change, including:

- The importance of making it possible for pharmacists to support patients in achieving and optimizing hypertension control.
- The vital need to align incentives for hypertension management (both payer policies & payment models).
- How the securing of public funding can help advance both state and local programs focused on health equity and social determinants of health.
- The ways in which policies that support the expansion of state Medicaid coverage of SMBP can help to address barriers to the implementation of SMBP.
- The impact that can be made by bolstering programs that address the high prevalence of uncontrolled blood pressure, including programs that: 1) remove economic barriers to prescription coverage for effective medications, 2) provide community-based support for individuals with hypertension through community health workers, 3) promote strategies for sodium reduction.

Following the presentation, a brief Q & A took place. This Q & A centered on hypertension as it relates to women, including the need to extend postpartum Medicaid coverage for 12 months post birth, and the importance of shifting the culture to see hypertension an urgent priority for women's health overall.

NHCR Strategic Framework Small Group Discussion - Part Two

For the final session of the meeting, NHCR participants were once again separated into three small breakout groups moderated by the meeting facilitators from Commonality, Inc. Although the exercise was the same as Day One (each group was asked to review an objective from the NHCR Strategic Framework, and share thoughts regarding what is needed to achieve success), participants were re-sorted and assigned to a different objective in order to ensure maximum feedback. The objectives discussed were:

- Foster partnerships to support population-level control of hypertension
- Amplify and advance effective hypertension control programs and practices to improve clinical and community systems
- Catalyze funding and payment systems to advance equitable hypertension control

The session closed with a call-to-action for participants, asking them to help NHCR advance these objectives by joining one of three Action Teams to be established in the months ahead. Notes from each breakout group session can be found in Appendix A.

Closing Remarks

To conclude the meaningful two-day meeting, Dr. Sanchez from the AHA once again took the virtual stage. In his remarks, Dr. Sanchez thanked meeting participants for their time, dedication and feedback, noting that their efforts today and moving forward would help advance the NHCR's goal of achieving blood pressure control for all in the United States.

The following summary captures the key learnings revealed throughout the meeting's proceedings:

Key Learnings

- The NHCR's new guiding principles and Strategic Framework have been crafted with input from NCHR membership to guide the organization's purpose and impact over the next several years.
- Structural inequities and social determinants of health are associated with increased risk of hypertension and cardiovascular disease; to make real change, society must address the unacceptable, longstanding disparities in care and access to care, and:
  - Ensure community members have a "seat at the table" during the design and implementation of programs and interventions
  - Encourage collaboration between clinicians and allied health providers (e.g., pharmacists, health educators and community health workers) to meet community members where they are and support them when and how needed
  - Remove barriers to care, including medication copays, and ensure all individuals have adequate insurance and an identifiable source of primary care
- Health system innovation can help move the needle on hypertension:
  - EHR systems should be leveraged to improve team-based care collaboration, to better reflect social determinants of health and care quality, and support continuous, accurate tracking of blood pressure for patients
  - Payment systems must be transformed to better support the work of allied health care providers, patient educators and community organizations, including the consideration of value-based (vs. fee-for-service) models of reimbursement
  - SMBP is a tool that should be rolled out more universally to move the needle on hypertension and advance personalized care
- Cross-sector collaboration and partnership is key to improving blood pressure, both at the national and community levels:

- To overcome provider inertia and advance consensus on blood pressure staging and control levels, hypertension must be made a national priority
- A business case for hypertension control must be made to incentivize insurers, self-insured employers, and other leading organizations to expand support services
- Policy should be leveraged to expand both access to clinical care services (e.g., Medicaid coverage of SMBP), as well as access to national and local programs focused on health equity and social determinants of health.

Recommended Next Steps

As NHCR embarks on this next phase of work, Commonality recommends it prioritize the following action steps in the immediate future:

- Finalize all focus areas of the Strategic Framework, inclusive of outcomes and time horizons.
- Draft call-to-actions for each of the three Action Teams, urging members to sign up for at least one Action Team for coalition year 2021-2022.
- Supported by the Strategic Framework, NHCR should identify clear and achievable action steps for the Action Teams and the NHCR to focus on over the next year.
- NHCR should prioritize the development of:
  - Standard operating and governance procedures
  - NHCR reporting structures and areas of responsibility
- Discuss and identify potential new NHCR members and formalize and implement a membership outreach and recruitment process.

Appendix A: Breakout Exercise Worksheets

Day 1

Catalyze Funding and Payment Systems to Advance Equitable Hypertension Control

Moderated by Jenny Bogard and John Clymer

To be successful on this objective, what does the action team need...

From a health equity perspective?

- Data that would underscore the significance of health disparities, in order to be consistent in the messaging; can create an infographic that looks at different relevant data and elevates this message broadly
- Must build trust in underserved communities; community health workers and clinicians can help to building a team of trust
- Payment protocols matter: must bring all stakeholders at the table, and ensure all voices are heard (place and race matter)
    - How are we building quality?
    - Payers who pay for performance
- Share models of care: where it is successful, and components of what is successful
    - Example: CA Chronic Care Coalition is currently sharing success stories (patient and pharmacist)

From a resource perspective?

- How do you make the business case for community health workers, support services, and care coordinators?
- Clear analysis of where problem actually is; need a problem statement
- Focus on quality measures; more value based approach
- Concerted effort that we have a good a payer mix in the NHCR (ex-CMS), including innovative payers that are addressing hypertension in an innovative and successful manor
- Benefits of NHCR: 1) sharing practices 2) NHCR comes up with criteria on better success in managing blood pressure
- Misalignment of incentives is one of the biggest challenges for providers
- Harvest possible resources that exist and make those existing resources visible

- Action team: collating info/data on the existing payment systems on hypertension (e.g., how are they dealing with meds, out of office monitoring, etc.) - bring together payers and understand what they are currently doing
- Get the info in front of the right people who can drive change
- BERTHA program

Amplify and Advance Effective Hypertension Control Programs and Practices to Improve Clinical and Community Systems

Moderated by Sharon Nelson and Anne Valik

To be successful on this objective, what does the action team need...

From a health equity perspective?

- Transparent data by group/system - publicly available - is critical
  - E.g.: share stories, share best practices, share data on a community level
  - Accountability for results (3 drivers: A1C, blood pressure -140/90, LDL -100)
  - Financial incentives (payment for results, e.g., for reduced heart attacks)
- Patient-centered approach - must be in the conversation and in the room to drive the direction of the work
- Need culturally-competent approaches to make sure the patient and families (caregivers, etc.) are at the center of whatever we propose
- Advancing the provision of care to meet people where they are (nights and weekends, telemedicine - but with telemedicine, must remember that many patients living with disparities have limited minutes, no access to broadband - can leverage the telephone, vs video, etc.)
  - Partnerships with community health workers, pharmacists, etc. who go to homes, who reach within the communities, etc.
  - Example: Health Partners in Minnesota has a telephone based pharmacist health coaching platform

From a resource perspective?

- Advocate for expansion of local programs more nationally; support the scaling of community-clinical linkages. (e.g., AHA “Check, Change, Control”, or CCC program)
  - Aha CCC program was too resource intensive to be scaled - but did serve as a basis for future work
- With the advent of telehealth and telemedicine, some programs previously seen as too resource intensive (i.e., CCC) should potentially be revisited again (especially for those not already accessing primary care; can be leveraged with partners in the field)

    - Select a few in particular that are evidence-based and effective and focus on scaling, but make sure the resources are there to bring them to life
- Think of payment for community health workers; are there enough pharmacists to advance this work?
- Local challenges with resources: what can the federal government do to support social determinants of health, and how can it leverage local systems?

From a partner perspective?

- Faith-based communities
- United Way 211
- In communities where we want to achieve control - look at media personalities, community leaders, and celebrities from those specific communities to serve as champions for heart health; reconfirm patient-centered approaches
- Go where the people are: community organizations, etc. - take the care to them
- Consider how to meet younger and younger people (social media), and older people - and how do we reach voices they respect?
- Urban leagues - located in all major cities - may be able to have a partnership

From an information or data perspective?

- Physician workforce knowledge gap - national program needed with required continuing education with testing of the clinical workforce, to make sure medication titration is happening appropriately
- Stratify data to the patient-individual-physician level-race-ethnicity, in order to help us see if we have a gap

What else are we missing?

- Time is the biggest barrier from providers
- Consider a national program to enable all to have access to telephone-based hypertension coaching from a nutritionist or pharmacist, and SMBP equipment, without copays

Foster Partnerships to Support Population-Level Control of Hypertension

Moderated by Eduardo Sanchez and Elizabeth Vegas

To be successful on this objective, what does the action team need...

From a health equity perspective?

- Underserved patients have a hard time accessing the health care system; we need to give care to patients where they live, visit. Medicaid patients visit pharmacies 2-3 times a month; meet people where they are
- 150 million employed people - we work in places where tech is harnessed; thinking about benefits and programs that can support employees (e.g., healthy food in the cafeteria, helping people make healthy choices, walks etc)
- How can we use technology; telehealth?
- Timing matters: convenience and flexibility - traditional hours of 9-5 aren't convenient for most people. Off hours, they can see community pharmacists and others
- Could we create incentives for patients?
- Appreciate competing priorities on their time and resources; make it as easy as possible for people to get the care their needs
- SMBP - extending the net of care from their homes (community health workers can help troubleshoot with some of the tech or logistic issues)
- Libraries and school settings
- Keep in mind those that aren't insured by employers; i.e., the full population

From a resource perspective?

- AHA just released a report on driving equity in the workplace; employers have a wide range of issues they might want to tackle (e.g., mental health, etc.); NHCR can play a role of helping employers through their CEO roundtable
- Finding ways to integrate services into employer settings and promoting them and what kind of programs can they adopt (e.g., maybe blood pressure cuffs available in lunch rooms)

From a partner perspective? Who might enable these partnerships?

- Value-based payments

From an information or data perspective?

- Make it easier to share data; interoperability between systems and devices and platforms
- AHA landscape analysis on remote patient monitoring platforms; social needs platform analysis (be part of data providers, suppliers and analytics). Better connections between community and clinical care is critical. What are the commonly needed services; when they are commonly addressed we see these outcomes - roundtable can play a role in highlighting the opportunity and catalyze solutions to add to the evidence base
- Keep in mind the digital divide - these approaches may not work everywhere; a lot of the population don't have access (e.g., rural, underserved). Critical to be sure we have equity in the data we have and don't have
- We need a clear data strategy - what are we trying to do? And how do we translate that to the local level (national strategies don't always translate to the community

level). Measurement is very important. Communities are left out because they don't have access to technology

From a marketing perspective?

- Marketing materials that speak to the right audiences - lived experiences from the community; materials for non-english speaking populations. Materials should reflect the communities they serve, with cultural intentionality
- Market research, survey and testing assumptions based on those surveys; community-engaged and community-centered marketing. Representation matters (e.g., case studies from barber shop program)
- Have the ability to track and pivot
- Audience profiles - develop segments and prioritize them

Day 2

Catalyze Funding and Payment Systems to Advance Equitable Hypertension Control

Moderated by Sharon Nelson and Jenny Bogard

To be successful on this objective, what does the action team need...

From a health equity perspective?

- Federal policy change to address hypertension
- Protecting employees; (military) labor shortage may advance this as a priority
- Determine the carrot to public and healthcare organizations
- Joint letter signed by member organizations
- Leverage COVID-19 argument
- Federal levers being pulled during COVID-19 (model those)
- Have someone present on those levers (possible webinar)
- Provide employers an easy template on what hypertension is costing them as an employer (e.g., via the National Business Group on Health)
- Editorials
- Raise awareness in public of controlling HTN as a means of surviving COVID-19
- Social media opportunities
- Engage actuaries; make financial case on what is being wasted without hypertension control
- Are there federal economists that can help with estimates on financial loss with uncontrolled hypertension?

- Current guidelines essentially exclude 30 mil people who have BP between 130/80-90
- Need to follow the science with appropriate guidelines (move away from 140/90)

Amplify and Advance Effective Hypertension Control Programs and Practices to Improve Clinical and Community Systems

Moderated by Eduardo Sanchez and Anne Valik

To be successful on this objective, what does the action team need...

From a health equity perspective?

- Make sure the populations you're addressing are at the table as part of the solution
- Recognize that each community is different (state, community, county, local, neighborhood); this advances the need for multi-level strategies and empowering leaders across all geographies, communities, etc. (with training, technical assistance, coaching, etc.)
  - Potential for a community dashboard - what do they need to advance this mission on the local level (e.g., worksheets, community assessment, SWOT, etc.)?
  - Make visible the resources the communities already have that address SDOH - can all of that inform a dashboard? Don't recreate the wheel, but fill gaps.
- Not having a usual source of care/not having seen a provider/not having insurance is all a predictor of poor blood pressure control. Must have a ticket to get in the door. If you're not getting care, you're in the inequity category - must focus on this as a baseline to articulate the health equity perspective
  - Ensuring all have access to the medicine they need, when they need it. Do everything we can to ensure the highest quality care is provided, regardless of where or when. May mean navigating barriers to medication (transportation, cost, access, etc.)
- Implementation is a challenge.

From a resource perspective?

- What is the opposition/friction to moving the needle in terms of implementation, and then what resources do we need to counter that opposition? What "sales materials, tools, assets, success stories" etc. are needed to advance buy-in? Different needs may exist in different communities, from a resources/resistance perspective

- A better business case for controlling hypertension; may need different versions based upon the audience you're trying to convince (e.g., health systems, employers, etc. - always aiming at the CEOs and board members)
- Name a payer that has put high value on blood pressure control? Must advance the incentivization for this
- The business case must speak "business" - it can't be public health speak. Language is important. Must meet the audience.
- NHCR should be careful of language in general - if things don't make business sense it won't happen.
- Must need the teams in place to achieve good outcomes - it's not just on the MD's shoulders

From a partner perspective?

- Community leaders
- Payers (large employers)
- Cardiovascular disease is a big driver of employer costs - must make the business case to incentivize the care (e.g., reduce high cost claims, day-to-day general care)
- It's a complex system; must think of the up- and downstream connections of the gears when it comes to developing the business case
- Leaders of healthcare organizations - must hear from and try to have an action plan begin to address or reconcile blood pressure control as an objective - make it a focal point for their work
- Patient-led community partnerships (especially racial, ethnic groups) that could provide significant input must be included; it's critical to lead with patient voices particularly for SMBP
- It requires a multi-system, multi-component, multi-interventional approach across partners to get understanding and put the pieces together to make it happen

From an information or data perspective?

- The Diabetes Prevention Program has gotten resources, promotion, etc. for success; it can serve as a good model for hypertension
- NACDD's members are health department staff that are funded by CDC to carry out hypertension control. There are hypertension programs that have been successful; can we develop criteria that are needed for successful hypertension control programs? What do we need to meet?
- Data + surveillance modernization offers lots of promise - should look at EHR-based surveillance for chronic disease management; know more real-time data related to hypertension control, which will help with implementing the right programs in the right places, and evaluating their impact in a more meaningful way to note progress and spread them in communities

- Some data comes too late and isn't actionable. Use a Quality Improvement model to act on it in real time (less retrospective)
- What are the outcomes that come from interventions? Can we benchmark this?
- What "scoreboard" can we create to evaluate and mark progress?
- Must be brutal in terms of prioritization
- Can the roundtable create a means to identify success factors? What 3-5 things are in common across best practices, and how do we make them the priority?

Foster Partnerships to Support Population-Level Control of Hypertension

Moderated by John Clymer and Elizabeth Vegas

To be successful on this objective, what does the action team need...

From a health equity perspective?

- Let's involve the patient, their families and support systems
- Nonprofit patient advocacy organizations
- Community health workers; social services
- Go to where people work, play, and pray
- Being conscious about bringing new partners to the table; be open to new ideas
- Faith based organizations: meet people where they are; people trust their faith based leaders
- Media: if the media was engaged (they are looking for patient stories), it would help a lot. How can we engage the media to get these stories out?
- Agriculture: migrant workers, food production industry workers. Connect with the National Center for Farm Worker Health and Food Chain Workers Alliance
- Employers - it's usually white collar organizations, better socio-economic status Think about a multi-pronged approach, which includes small- to mid-sized businesses. Help employers implement things that are practical - meet them where they are
- National Business Group on Health

From a resource perspective?

- Telehealth: how do we bridge the digital divide and internet access? Must think about equitable access to telehealth and how can employers provide access - especially in rural areas
- Self monitor blood pressure devices; think about packaging a model
- Develop business cases: what would be the benefit to the employer to cover services in a different way (e.g., as self-insured employers are interested in costs, productivity, days lost etc.)

- Employers need to see why it's important to cover hypertension and its excellent ROI (there is a lot of research that already exist)
- Working with payers to revamp the way they incentivize better hypertension care.
- Behavioral economics strategies (multiple business cases can be made from different vantage points)
- Screening is a big opportunity for employers
- Value in partnering NAM roundtable on population health - engaging the business sector
- Opportunity to partner with other coalitions who are working on issues that go across other chronic conditions - like telehealth

From an information or data perspective?

- What are the measures that we are going to be focused on meeting the goal? It's a fundamental decision that needs to be made
- Collaborative agreement on how to share the data in real time
- Interoperability data
- What are employers currently doing for hypertension - survey perhaps?

From a marketing perspective?

- Campaigns: Public awareness (e.g., Be there San Diego - be there to see your child graduate - and Million Hearts); opportunities to engage legislators
- Patient stories are very powerful
- Stigma - people feel self conscious about letting their employer know they have hypertension
- Lessons learned about how community providers have come together to address vaccine hesitancy; developing materials that can be provided to trusted members to the community to deliver the message. Trusted Messengers are critical
- Culturally competent messaging, appropriately translated
- Once you engage people, you can use social media to continue to message them

Appendix B: Shared Resources

- Association of Medicaid Expansion With Changes in High Blood Pressure, Diabetes Control
- 2019 AHA/ACC Clinical Performance and Quality Measures for Adults With High Blood Pressure: A Report of the American College of Cardiology/American Heart Association Task Force on Performance Measures
- Pharmacists' Patient Care Process Approach Guide
- Theories for social epidemiology in the 21st Century: an ecosocial perspective
- Association of Medicaid Expansion With Cardiovascular Mortality
- 2017 Guideline for High Blood Pressure in Adults
- 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines
- Hypertension Control in the United States 2009 to 2018: Factors Underlying Falling Control Rates During 2015 to 2018 Across Age- and Race-Ethnicity Groups
- Community Health Workers: Evidence of Their Effectiveness
- To Advance Health Equity During COVID-19 and Beyond, Elevate and Support Community Health Workers
- YMCA's Blood Pressure Self-Monitoring Program
- Using the Pharmacists' Patient Care Process to Manage High Blood Pressure: A Resource Guide for Pharmacists
- Hypertension Management Program (HMP) Toolkit
- Implementing High-Quality Primary Care
- NACHC Million Hearts® Initiative
- Behavioral Health Consultant Hypertension Toolkit
- Find Help
- 2019 AHA/ACC Clinical Performance and Quality Measures for Adults With High Blood Pressure: A Report of the American College of Cardiology/American Heart Association Task Force on Performance Measures
- American College of Healthcare Executives
- Controlling High Blood Pressure: An Evidence-Based Blueprint for Change
- Methods and Resources for engaging Pharmacy Partners
- Joint Policy Statement on Expanding Access to Healthcare Every day and During the COVID-19 Response
- Call to Action: Maternal Health and Saving Mothers: A Policy Statement From the American Heart Association
- Working Agenda for Black Mothers: A Position Paper From the Association of Black Cardiologists on Solutions to Improving Black Maternal Health

- The Surgeon General's Call to Action to Improve Maternal Health
- Counter Cholesterol Organization
- AHA Statement: Pregnant women with CVD need specialized care before, during and postpartum
- Association of Black Cardiologists Webinars