Centers for Disease Control and Prevention

Hypertension Control Meeting
September 9-10, 2019

Summary Report

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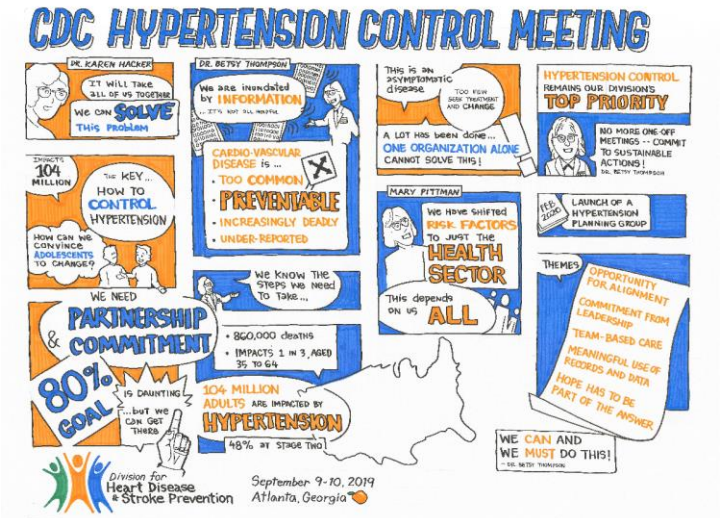
Executive Summary

On March 21, 2019 the Centers for Disease Control & Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention hosted a gathering of national thought leaders and experts on hypertension control and cardiovascular health to inspire a "charge to action" towards private and public partnerships to address the persistent challenges of millions of people working to manage hypertension in their daily lives. That meeting laid the groundwork for the Hypertension Control Meeting held on September 9-10, 2019 in Atlanta, Georgia.

Public and private sector stakeholders[1] including health care providers, employers, non-governmental organizations, insurers, academia, and state public health agencies gathered for the two-day meeting in Atlanta to pursue a national agenda to achieve 80% hypertension control. As the host of this historic agenda setting meeting, the Centers for Disease Control & Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention in partnership with the Public Health Institute's Center for Collaborative Planning (PHI/CCP), gathered over 100 national thought leaders and experts on hypertension control and cardiovascular health to design solutions and to articulate commitments for collective action. A key focus of discussions and planning activities centered around scaling practices and policies that are already known to work and helped to meet the following objectives:

- Share best practices for proven hypertension control strategies
- Develop a plan of action to share and promote proven strategies to improve hypertension prevention and control
- Obtain commitments from participating groups to implement proven strategies.
- Identify specific supporting roles that CDC can play in the implementation and promotion of hypertension control strategies.

Highlights from key discussions among these thought leaders and subject matter experts are offered in this report for continued conversations and actions by other stakeholders and communities.



[1] See Appendix I for the list of meeting participants.

Current Landscape of Hypertension Control

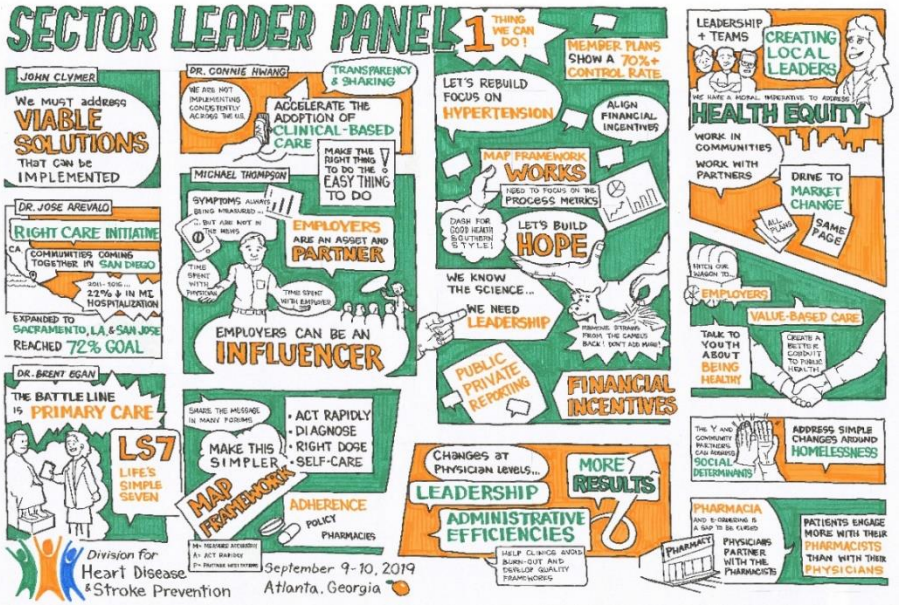
To understand the current landscape and "appetite" for hypertension control and to illustrate promising practices, a panel of leaders representing diverse sectors including health care purchasers/employers, insurers/payers, clinicians, non-governmental organizations, and academia engaged in a discussion about what's working and "low-hanging fruit" to build momentum on reducing hypertension rates. John Clymer, Executive Director of the National Forum for Heart Disease and Stroke Prevention, facilitated a robust discussion with panelists including Dr. Jose Arevalo with Sutter Independent Physicians, Dr. Brent Egan, Vice President for Cardiovascular Disease Prevention at the American Medical Association, Dr. Connie Hwang, Chief Medical Officer with Alliance of Community Health Plans, and Michael Thompson, President & CEO of National Alliance of Healthcare Purchaser Coalitions. Following the panel presentation, Dr. A. Mark Fendrick, Director of University of Michigan's Center for Value-Based Insurance Design offered innovative payment solutions that invest in high value care. A synopsis of these presentations and discussions follow.

Key Take-Aways from the Panel Discussion[2]

The challenge in addressing hypertension lies not in what is required for control but in implementation and ease of compliance. Multi-disciplinary teams, good data, and financial incentives based on clinical and patient experience goals were highlighted as important components of moving towards the goal of 80% hypertension control.

Responding to the question of, "What's the one thing that needs to happen in order to apply what we know works?", panelists advocated for partnerships with employers, the community, and primary care providers; improved access to and sharing of data; team-based care; enabling leadership to embrace this issue; and focusing on health equity and cultural competency.

Utilizing a population health focus, aligning financials with value-based care, and optimization of care quality and costs were offered by the panelists as existing strategies to which this work can be aligned in order to move the needle on hypertension control.

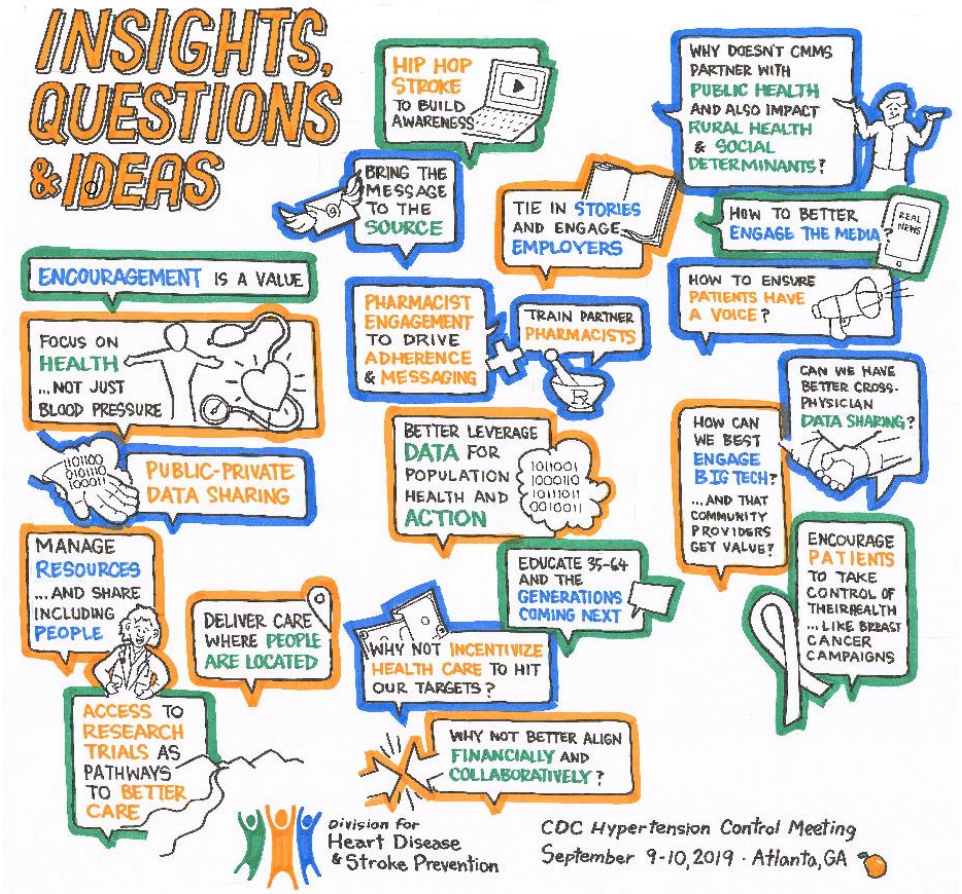


[2] See Appendix II for notes from the panel discussion.

Meeting participants had an opportunity to discuss, in small groups, what insights they gained from the panel discussion as well as how they might apply the ideas that were brought forward to their own work.[3] Two themes that emerged were making the right thing to do the easy thing to do and improving partnerships, particularly with pharmacists, employers, and the community.

Ideas for the application of proposed approaches and solutions focused on team-based care and, particularly, working with nurses, pharmacists, and patients to improve adherence and control.

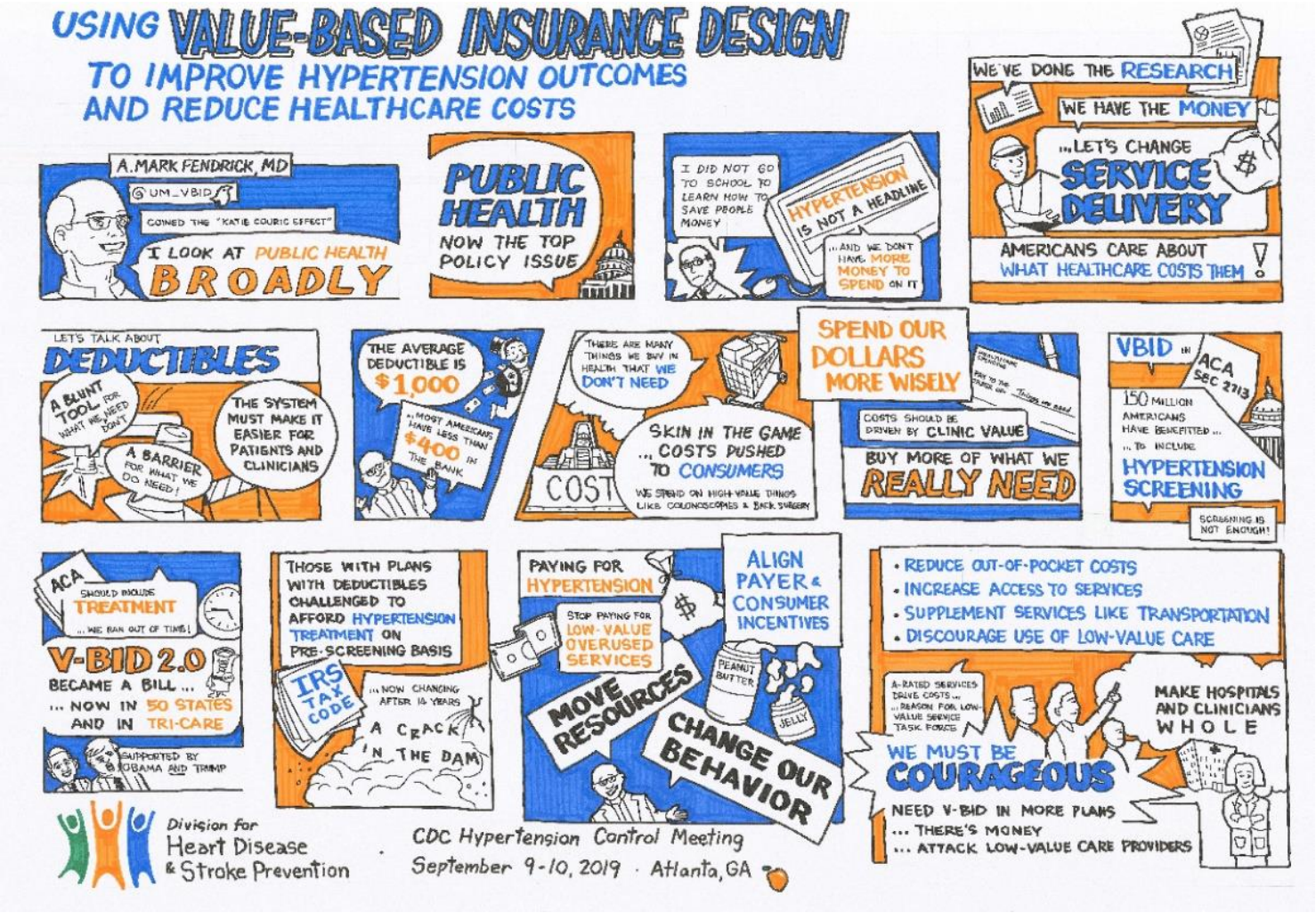
Questions about messaging, improved access to standardized data, incorporation of prevention strategies, and cross-sectoral approaches were raised as issues for further exploration.



[3] See Appendix III for notes from this session.

The second day of the meeting started with a presentation from Dr. A. Mark Fendrick on value-based care.[4] Dr. Fendrick recently achieved significant policy wins with the U.S. Department of Treasury regarding the expanded use of health savings accounts for certain chronic conditions. If adopted widely, this rule could reduce the cost barrier for individuals attempting to treat chronic illness.

In his presentation on value-based insurance design, Dr. Fendrick suggested that the current metrics of cost of care and "how much" need to be shifted to a focus on health and "how well" care is being delivered; essentially shifting from volume-driven to value-driven strategies. By investing more in high value care and less on low value care, resources will be freed to focus on approaches that will generate better health outcomes. Dr. Fendrick's presentation set the stage for the remainder of the day with participants examining best practices they could adopt and advance to control hypertension within their organizations.



[4] See Appendix IV for notes on this presentation

Design Lab: Challenges, Solutions, and Creating Actions for Path Forward

Using design process and questions, participants gathered in cross-sector groups to identify challenges, solutions, and action steps to scale and apply best practices to hypertension control including: Team-based care, self-management/self-measured blood pressure, reducing out of pocket costs, clinical decision support, integration of community health workers into care team, medication therapy management/collaborative practice agreements, and public activation/campaign engagement. Highlights from the discussions on solutions and action steps are captured below.[5]

Clinical Decision Support

Integrated, high quality data for hypertension management and control was identified a key solution with action steps including:

- More out-of-office monitoring
- Minimizing the burden of transmission of data
- Business models to support sharing of data and alignment of incentives

Community Health Workers

Using specific, community-health worker interventions was identified as a key solution, with action steps including:

- Targeting community health worker resources to populations that would most benefit
- Developing an easily acceptable toolkit

Employer Based

Including medication therapy management as a covered benefit/standard of care for self-insured employers was identified as a key solution, with action steps including:

- Partnership development with other organizations
- Identification and elimination of obstacles to care
- Innovative approaches and positive results

Public Awareness

Focusing on Million Hearts messaging was identified as a key solution, recognizing that increasing public awareness is a journey.

Reducing Out-of-Pocket Costs

Improving patients' experiences by making the right thing the easy and affordable thing was identified as a key solution, with strategies including: learning more about optimal cycles for drug refills, best partnerships for getting medications to patients, and actuarial turn-around on downstream savings.

[5] See Appendix V for notes from this session.

Self-Management/Self-Measured Blood Pressure

Integrating patients' measuring of numbers with understanding of health implications and motivators, coupled with a connection loop, was identified as a key solution, with action steps including:

- Validated, free measurement tools
- Plans covering self-measured blood pressure
- Community support of bi-directional data
- Public/patient education on awareness

Sustainable Medication Management

Alignment was identified as the key solution, with action steps including:

- Implementing an aligned payment model
- Public awareness
- Safe, two-way data sharing
- Standardizing the Q1 process

Team-based Care

Positioning patients as members of their care teams was highlighted as a key solution, with action steps including:

- Embracing a common understanding of team-based care
- Implementing treatment protocols
- Developing a hypertension control action plan

Commitments to Achieve Hypertension Control Rates of 80% and Next Steps

Based on discussions about best practices, participants explored ways that they could uplift and move action towards 80% hypertension control from the perspective of their own sector.[6] In addition to sector-specific commitments, CDC identified immediate next steps to build out the national agenda and call to action including the launch of the Hypertension Control Consortium in 2020. Participants articulated individual commitments and next steps to add even greater momentum to the national call to action.[7]

Academia/Research

Ideas for building momentum included:

- Using implementation science to make sure translation of evidence-based care reaches populations most in need (Improve, not exacerbate, disparities.)
- Need for partnership/teamwork with other sectors
- Need for tailored research in specific populations
- Greater knowledge in healthcare economics
- Policy changes/advocacy – step out of comfort zone
- Tackle issues related to access to screening/treatment (lifestyle and drugs)
- Working with communities where academic centers are located. Regional thinking/collaboration. (Example: Right Care in South Dakota)
- Testing of combo pills – effects on adherence, side effects, BP lowering. (Gummy bear "pills" – chewable)
- Comparative effectiveness research on multifactorial interventions

Health Care/Clinicians

Ideas for building momentum included:

- Continuing education on patient blood pressure monitoring
- Community health workers to be patient-centric not disease-focused
- Doing a better job of writing evidence-based guidelines
- Providing additional avenues for patient engagement and interaction beyond the offices
- Family engagement
- Alignment of incentives to promote quality outcomes, including care Building champions – storytellers
- Keep dissemination partners connected
- Identify functions and outcomes communities need to be successful
- Building champions – pastors
- CDC self-evaluating the process
- Having stories to tell/build champions
- Identify outcomes and functions, competencies, or community leaders needed to deliver outcomes
- Role of NGO = convene or co-convene
- Reimbursement, especially for the uninsured, must include the community and individual
- Building the competency of community and adequately resource the partner

[6] See Appendix VI for notes from this session.
[7] See Appendix VII for notes from this activity.

Payers

Ideas for building momentum included:

- Develop innovative category of preventive benefits
- New payment models for medicate therapy management services
- Improve wrap-around services to enhance patient experience (transportation, convenience, reminders, engaged working with community-based partners e.g., providers, community health workers, pharmacies.
- Coordination among plans for common formulary of anti-hypertensives

Pharmacy

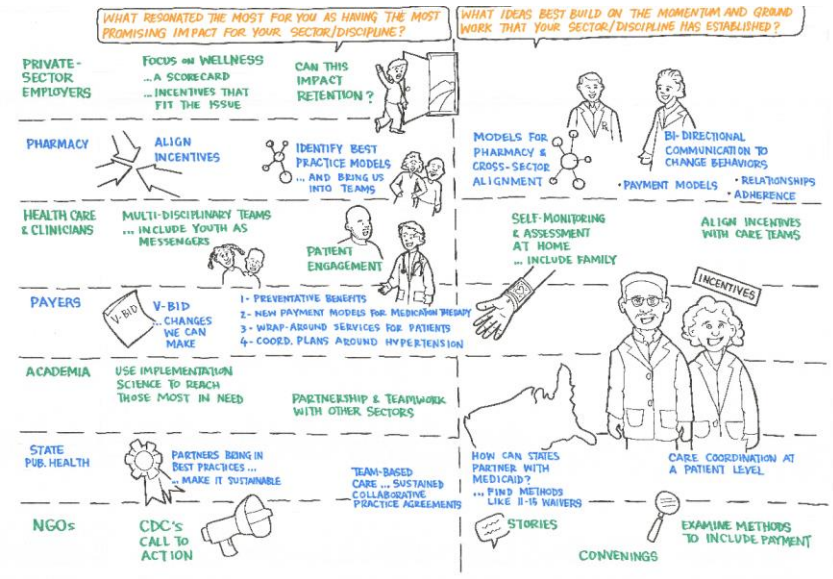
Ideas for building momentum included:

- Pharmacy on roundtable board
- Establishing bi-directional communication
- Payment model to support service
- Developing trusting relationships with providers
- Hitch hypertension to adherence

State Public Health

Ideas for building momentum included:

- Medicaid partnership
    - Per Member Per Month (PMPM) -> funding for public health
        - Team-based care/high-risk case management
- Community health workers
- Collaborative practice agreement
- Non-traditional public health team-based care
- Employer wellness programs
    - Link with public health
- Non-traditional funding



Convening Photos


CDC HYPERTENSION CONTROL MEETING
SECTOR LEADER PANEL
DR. KAREN HACKER
IT WILL TAKE ALL OF US TOGETHER
WE CAN SOLVE THIS PROBLEM
DR. BETSY THOMPSON
WE ARE INUNDATED BY INFORMATION
IMPACTS 104 MILLION
THE KEY... HOW TO CONTROL HYPERTENSION
HOW CAN WE CONVINCE ADOLESCENTS TO CHANGE?
CARDIOVASCULAR DISEASE IS...
• TOO COMMON
• PREVENTABLE
• INCREASINGLY DEADLY
• UNDER-REPORTED
A LOT HAS BEEN DONE... ONE ORGANIZATION ALONE CANNOT SOLVE THIS!
MARY PITTMAN
WE HAVE SILOED RISK FACTORS TO JUST THE HEALTH SECTOR
THIS depends ON US ALL
WE KNOW THE STEPS WE NEED TO TAKE...
WE NEED
PARTNERSHIP
COMMITMENT
80% GOAL
IS DAUNTING
...BUT WE CAN GET THERE
860,000 deaths
IMPACTS 1 in 3 ADULTS 35 TO 64
106 MILLION ADULTS ARE IMPACTED BY HYPERTENSION
48% at STAGE TWO
Division for Heart Disease & Stroke Prevention
September 9-10, 2019
Atlanta, Georgia
INSIGHTS QUESTIONS IDEAS
INFLUENCER
LEADERSHIP

Appendix I

Participant List

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Appendix II

Sector Leader Panel: Opportunity Knocks for Hypertension Control

Dr. Jose Arevalo, Sutter Independent Physicians

- Goal of the Right Care Initiative is to move towards zero preventable heart attack, stroke, diabetes, and heart failure deaths and disabilities
- Need to use the best available science as well as proactive screening and outreach
- University of Best Practices shares innovations and lessons learned
- Collaboration is an essential ingredient for success

Dr. Brent Egan, American Medical Association

- Hypertension control is not rocket science – we know what to do; need implementation science and translation of what we can do
- Primary care is the battleground. We need to make life simpler for providers
- Partnership with public health to address lifestyle issues/challenges
- 80% rate reduction – sufficient medication to treat and self- manage condition
- Shared decision-making on treatment plan
- Single pill combination to make compliance easier
- MAP framework for chronic disease management leading to rapid and sustained blood pressure control
- "Be There SD" is an example of programming that resulted in 27% decrease in chronic disease over 5 years which required data sharing across partners.

Dr. Connie Hwang, Alliance of Community Health Plans

- Focus is on integrated care plans that roll-up services
- Received Pecori Award which accelerated adoption of evidence-based care
- Successful payer-provider relationships centering on: Leadership, multidisciplinary teams, continued education. Made the right thing to do, the easy thing to do.
- Data, aligning financial incentives with clinical and patience experience goals
- Importance of sharing openly and stealing good ideas shamelessly

Mike Thompson, National Alliance of Healthcare Purchaser Coalitions

- NAHPC represents a network of 40 public and private sector employers/members including unions
- Employer's perspective: Good and bad news. 85% of employers working on health but not much happening with varying impact. Similar to the lack media attention, hypertension control hasn't generated much hype among employers/businesses.
- Current focus on mental health, obesity, oncology, opioids. Employers can be allies in this work as solutions for hypertension control are same for other issues as well.
- Need influence on other parts of the system. Allies on the supply chain

Panel Discussion:

Question: What's the one thing that needs to happen in order to apply what we know works?

- Employers – re-education to rebuild attention on hypertension control
- Primary care – optimize and reimbursement
- Commercial population currently at 52%; South & White Health Plan with 38,000 members between 2013-2019, blood pressure control rates now at 72%.
- Why? Because the health plan made BP a priority to include monitoring and study by Quality Improvement committee to determine what and how they execute. Requires transparent data sharing.
- Value-based business models that focus on BP control, particularly for medically acute populations. Incorporate Michelin scores
- MAP Target CP is growing – 8 million patients and now recruiting health systems to engage. Provide resources and regular feedback on key metrics across to track progress as well as outcomes.
- Promote healthy lifestyles – food that tastes good but doesn't cost more
- Access to adherence to evidence-based health care
- Have Hope to counteract the undervaluing of life; Raise hope that tomorrow will be better
- Over 100 practitioners of Million Hearts who have achieved at least 70% reduction in rates through Measure Up/Pressure Down:
    - Need financial incentives along with ongoing science; how do you make Hypertension a priority? Leadership
    - Limit the "straws" on the backs of primary care providers – incentivize team based care
    - Private/public reporting; dashboard on provider's work to create competition among providers to do better and avoid being at bottom of the list
- Leadership – call out and enable proactive leaders to step out and embrace issue; Tennessee rural example: leaders to steps in and generated data sharing
- Low hanging fruit?
    - Leadership that has administrative efficiencies
    - Design for efficiency; working hard and getting results
    - Casting a vision for folks to be willing to change
- Sutter Health has a champion for HPT control. Enterprise HPT guidelines and disease management platforms. Application and adaptation of EPIC system for data sharing.
- Healing in Plain Sight – A team approach to design guidelines
- Population health – disease management has become critical for the whole health care system. Cultural components including language and cultural competency to address chronic disease issues
- Galvanize Leadership through health equity lens to spur additional focus
- Dr. Winston Wong, Community Benefits with Kaiser Permanente – creating a moral imperative
- Community partnership – tied to community stakeholders such as health ministries, black health organizations
- Health Partners – used Medicaid as a proxy on quality measures

Question: Are there moving trains to which we can "hitch" our wagons to move the needle on hypertension control?

- Population health focus. Hypertension control is where most success/evidence exists. Less so for preventing hypertension
- Value-based care and aligning financials.
- Optimize quality and cost
- Manage risk for cardiovascular care – more income/revenue streams leading to real dollars available

Appendix III

Huddle Time Discussion Notes

What new/different insights did you gain from the sector leader panel?

- Influence youth to improve their health and health of families
    - School purchasing policies
- Public awareness
    - PR firm
    - What is our message? How do we make it meaningful?
    - Culturally specific
    - "Be There"
    - Specific interventions to access 18-64; target this group
- Care about your own health => hope
- Clinicians will work hard if seeing results
- Administration – need for this to help coordinating intervention
- Barriers
    - How do we overcome these, especially involving certain stakeholders (e.g., surgeons don't want to lose salary); (limit other groups, like pharmacists)
- Make the right choice the easy choice
    - Subsidize the wrong things (food choices in schools)
- Don't stigmatize risk factors and HD because can limit patient activation
- San Diego changes
    - HTN control rates improved
    - Attribution -> HTN control vs statins
- It can be done – hope
- Community involvement can have an impact
- "Administrative efficiency"
- Lack of fear – no emotional response
- Make the right thing to do the easy thing to do!
- Resistance to treat
- That the CEO of purchaser coalitions was surprised by the impact of uncontrolled HTN – and even more, by the fact that HTN control is not (yet) a national priority
- I have new belief – we can reach goal
- We need new approach – consumer-centered
- What is the mental model?
- What is the health belief model?
- For seismic change - where (do we) put money
    - Food bill
    - Availability/ease of healthy food
    - Hospital community dollars – driven by community
    - Wellness payment/coaching embedded in health benefits
    - Paying for SDOW support
- Expose youth to:
    - Farms

    - Health and wellness
    - School – identify developmental assets
- Transparent reporting and accountability are needed to get to 80%
- Raising awareness of the costs of unmanaged increased blood pressure is critical
- Need more public awareness to prioritize blood pressure control
- Identify ways to improve adoption and spread of best practices, like university of best practices
- Providers must be held accountable to prescribe evidence-based medications – 1st line, combos, etc.
- How pharmacy integrates within other models
- Ensuring med compliance
- Shift from late-stage intervention/treatment to prevention
- Comes down to money
- Incentives (all about a business model) to provide late-stage procedures for CYD -> need to focus on prevention
- Money first, health second
- Medical industry isn't super interested in fixing HTN because it hits their bottom line
- Increased self-management and community health workers
- Continuity of care between providers -> interoperability of systems
- US Territories do a better job of sharing information
- Digitized blood pressure
- FT/iPad digitizing
- Need more resources
- Scope of work -> has to fit within community resources available
- Need to operate within the context of which people live -> use market data
- Encouragement as a value
- "Systemness" has to be part of the answer
- Private-public reporting of dashboards
- A focus on health rather than just BP
- Millennial influence
- Community health workers and funding
- Incentive to drive behavior change
- Investment for tools/resources
- Employers not focused currently on HTN
- Get the employers to focus on the low hanging fruit
- Independent Health in New York (what independent pharmacists did to support the patients who weren't at control)
- Let's include employers in the team-based care approach. Test concept for small, medium and large-sized employers
- Finance and payment models
- The lack of employer interest (and other interest) in hypertension as an area of focus

How might the ideas brought forward apply to your own work?

- BP reading may not be reviewed by physician prior to seeing patients
- Adherence is a focus for pharmacy. Can we run data to see if there is a correlation of prescribers so we can collaborate?

- Employers to educate (about) the importance of hypertension
- PSA needed
- Within a large health system, seeking a simplistic means to implement change that could have a broad effect
- Maximize all members of the healthcare team, including but not limited to pharmacists
- Identify opportunities to improve self-management among patients, which requires access to tools/resources/devices as well as patient education
- Teaching home BP -> Need to educate clinicians how to teach SMBP
- Education of clinicians is critical – guidelines – understanding and implementing
- Access – pool information on same site. Many agencies can help with medical costs (i.e., Publix gives out free BP meds
- Teamwork – team-based care is critical
- Nurses are most trusted profession – should be utilizing
- MAP Framework for chronic diseases will be a framework that I consider for my future interventions
- Discussion about issues around accurate measurement to appropriate diagnoses
- Patient-centered adherence strategy needs to be widely practiced
- Insurance disparities – impact access
- To get to 80% in population, need 90% in clinical care systems (some aren't getting care)
- Systems of care
- Community health workers/navigators
- If we succeed in moving to high levels of BP control, "relapse" of those previously in control becomes a rate-limiting step for further improvement
- Expanded health work force
- Systemness; values; health; discipline; paradigm shift (patient/family focused); decisiveness; encouragement
- Hip Hop Stroke
- Bring the message to the source
- Relating to individuals like yourself
- Bundle our focus (BP, A1C, tobacco cessation)
- Pharmacy collaboration – cover it
- Employers as a member of team
- Patient driver
- What factors led to the success of the breast screening programs/support?
- Major partner (e.g., MLB, US Women's Soccer) similar to what Susan G. Komen has done with breast cancer
- Need advocacy groups, grants
- Need academic and data support
    - RAND -> helped collect data and reviewed data from "Be There" in San Diego
    - Public-private data sharing
- "Slicer-Dicer" on Epic
- "Team-based care" -> need play book (e.g., protocols) that all HCPs go by to make a difference
    - Need meaningful roles
    - Work to top of training

What questions remain for you?

- Total cost of care to patients that are hypertensive – for employers
- How do we better communicate across health care providers?
- More patient health data to help identify proper strategy
- How does it vary by…
    - Rural/urban?
    - Polypharmacy?
    - Multiple chronic conditions?
- Added cost…
    - Change compliance
    - With comorbidities
- To what extent is home blood pressure monitoring being used?
    - Incentivized?
    - Coupled with telemonitoring?
- How to make better use of community pharmacist skills/knowledge?
- Should there be greater standardization of number of blood pressure measurements?
    - In office
    - At home
- What are the high impact next steps to align financial incentives to control HTN?
- What can private sector do? (J. Ovelch, Harvard)
    - As employers (benefits)
    - In community
    - In products
    - In environment
- How each sector can activate around goal
    - Clinical care
    - Consumer
    - Finance
    - Community?
- How to incorporate wellness – not disease specific
- How can we improve reimbursement and financing to support evidence-based care by appropriate team members?
- Who should pay for prevention and management?
    - Payer
    - Employer
    - Individual
    - Provider
    - Community agencies
    - Etc…..
- How can we reduce increased deductibles for return visits (disincentive to return)?
- What will be the disrupter?
- Where does prevention fit in the continuum of HTN management?
- How do we systematically assess and address SdoH among patients with hypertension?

- What will it take to expand the scope of practice of nurses and pharmacists and compensate them accordingly?
- How can we promote accountable community organizations to increase local collaborative solutions?
- How can we achieve team-based compensation for care?
    - NP, PA, Pharm Ds
    - CHW, navigators
- What can we do to increase non-licensed personnel use in managing uncomplicated hypertension?
- Focus on mean BP
- New models of care
- Big data – top down approaches
- How to move from binary targets (<140/90, <130/90) in individuals and practices to mean BP+/- variation
- How to get more investment in public health/prevention vs. near-exclusive funding of "sick care"
- How do we implement bi-directional data between physicians, clinics and pharmacies?
- Where does the patient have a voice/representation?
- How do we work with food industries/restaurants to address HTN?
- How do we better engage media?
- How do we get CMS or health insurers to pay for support to patients on upstream and basic support (e.g., health literacy)?
- How does the money thrown to the health care system trickle down to take care of the above?
- What is the patient role in all this?
- What role can the employer play to be more supportive in HTN control
- What will it take to get the employers attention?
- Who can be the collective to do case management?
- Faster, useful data -> how do we get this?
    - EMR venders -> their business models aren't aligned to effect population health management
- Primary care re-design
- SOP changes -> message to threatened providers
- Innovations in BP taking

Appendix IV

Dr. A. Mark Fendrick: Value-Based Insurance Design

- We're currently focused on cost of care, not health
- "Katie Couric" effect on colon cancer
    - Elevate hypertension control as "workable" – cut rate of growth
- Deliver what we know will work
- Change discussion from "how much" to "how well."
- Moving from volume driven to value driven
- Patients care about what it costs them (out of pocket), not about health care costs.
    - A key source of concern for patients is out of pocket costs and deductibles; rising co-pays worsen disparities.
- Co-payments is akin to a tax on the poor and those with greater disparities: "Blunt Cost-Sharing"
- Determine what we should buy more (high value care) or less on (low value care). Reduce spending on low value care that then creates more resources on those items that have higher value for generating health.
- Align payer and consumer incentives – easy as PB & J
- Make it easy for patients and providers to do what they can to stay healthy

Appendix V

Design Lab Activity

Team-Based Care

Step 1

A. Clinical, Community, Policy/Systems, Environmental
B. Access
   More BP control
   Change from doc-centric PT centered
   More PT engagement and adherence
   More reimbursement
   (2) More adoption and acceptability
   (1) More understanding of team-based care and principles of TBC
C. Value based insurance
   BP control is high value service
   Align incentives

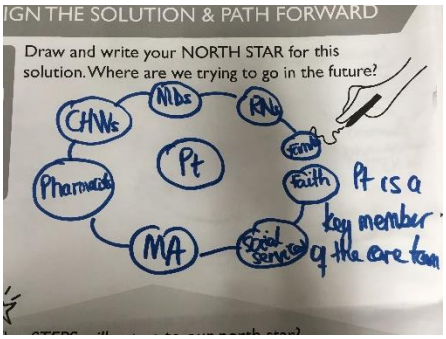
Step 2

(4) VBID for team-based care
Training healthcare professionals (IPE)
(3) Workshops to teach TBC
Partnerships with Community Pharmacies CHWs
(5) Improve communication b/n practices and community partners
Systems that talk to each other
(2) Redesign systems of care
Treatment protocols (pt-informed)
(1) Pt is part of the team scope of practices

Step 3

What steps will get us to our north star?

- Embrace common understanding of TBC
- Implementing treatment protocols
  - "HTN action plan"



Resources	Learn more about	Need from CDC
- BP monitors (SMBP)	- What are others doing	- Funding
- Treatment algorithms	- Reimbursement	- Proctors
- Coverage for prevention	- MI	- Evaluation
- Educational materials		

Self-Measured Blood Pressure

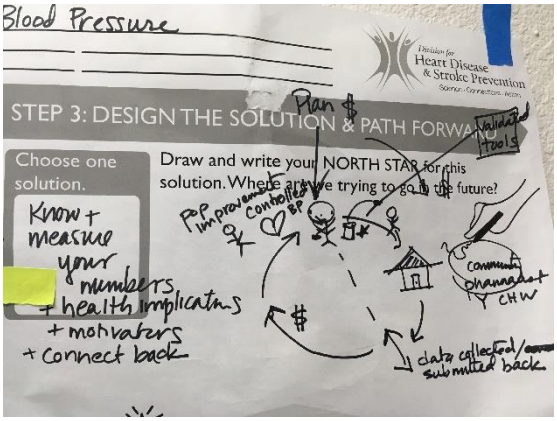
Step 1

A. Clinical, Community, Policy/Systems, Environmental (built)
B. Getting valid result- in office out of office discordant
   Ensure monitoring is connected back to systems
   Validated monitors/+ check it
   Educated public/spouse, individual + kid how to measure
   Educate physicians on validity of home monitoring
   Seamless EHR
   How to engage people and get data
   Validated list of blood pressure monitors (validators)
C. Get people to care…

Step 2

How might we address the challenges in the domain of ABCD self-measurement of BP, to meet the need for more consumers measuring more often in a more validated way and connecting back to Brov. and consider incentives, public education, policy change, better tech and personnel/personal support.

- Align incentives at measurement in-home in-office/Behavioral Economics
- Have a heart health ambassador, CHW or a telehealth tool
- Linking tech better/we have it use it better
- AWA validate monitor list (Canada Hypertension Canada)
- Education to allow correct measure
- More policy work targeted with HEDIS + NCQA
- Coverage for the monitors
- In Canada, they cover care (including CHW) not monitors- policy- look at it.
- Value-based care model/cover CHWs the Y
- Bluetooth scale? Resources? Personnel
- Effective tailored communications



Step 3

What steps will get us to our north star?

We need validated, paid for measurement tools, plans to cover SMBP, community supports data to be bi-directional, public/patient education on awareness.

Resources	Learn more about	Need from CDC
- Physician CHW/HCP - Tech providers - Consumers - NCQA/HEDLS - AMA/AHA	- Behavioral Economics for self-management	- $, TA - Ad campaign PSA→ - Drive valid tool process - help bi-directional referral - ROI Measures

Reducing OOP Costs

Step 1

A. Policy/Systems
B. Reducing costs of care for meds
- for patients
- for the system

Step 2

How much we address the challenges in the domain of policy/systems, to meet the need for reduced costs and consider the need to impact patient OOP and overall system.

Harmonization of formularies

- follow the evidence

Coverage for:

- home monitoring
- Medication Therapy Management
- nutritionists

Benefit Design:

- Make refills easier for patients
- Reduce OOP costs to # patients

Step 3

Improve patient experience

- make doing the right thing easy (and cheap!)

Resources	Learn more about
- PBMs - More private sector	- Optimal cycles for drug refills. - Best partnerships for getting drugs to patients. - Actuarial turn-around on downstream savings.

CHW

Step 1

A. Community
B. CHWs may be effective for specific populations
   Patient education
   Patient activation
   Patient navigation
C. Need to be patient-centric
   CHWs can influence care outcomes

Step 2

1. Stratify population to be better target and utilize CHWs
2. Utilize algorithms to select patients to target
3. Build business case
4. CHWs must become defined care team members/producers in policy
5. Make CHW toolkit more easily available to all
6. Strong relations between CHWs and community partners (e.g. pharmacists)
7. Solutions must be sustainable e.g. include CHWs in integrated health systems.

Step 3

Improve HTN outcomes using CHW specific interventions

What steps will get us to our north star?

1. Recommend practice for targeting CHW resources to population who would most benefit
   e.g. develop algorithms based on community
2. Develop easily acceptable toolkit

Resources	Learn more about	Need from CDC
- NACHW	- How to build?	- Convene stakeholders to
- State Medicaid Agencies	- What content?	review, test, finalize toolkit
- UBID team and network	- What could it look like?	- Disseminate final
- ASTHO	- How useful would the kit be?	

BP First Dalton: Employer Based

Step 1

A. Clinical, Community, Policy/Systems, Environmental (work, rural/peri-urban)
B. Engaging employees in appropriate ways with language, education
   Improved access to BP control
   Remove obstacles
C. Move to translation
   No more research needed
   Just do it!

Step 2

1. Screen for BP at work and contact employee with BP Dx
2. Offer MTM at work for employees that are uninsured
3. Offer pathway to care through CHW for uninsured

Step 3

MTM as covered benefit/standard of care for self-insured employers

What steps will get us to our north star?

- Partnerships
- ID and eliminate obstacles to care
- Innovation
- Positive results

Resources	Learn more about	Need from CDC
- Employer by-in	- How far can employer go	- SME
- Community resource		- Partner support
- Employee buy-in		
- Partner		

Sustainable Medication Management for HTN

Step 1

A. Clinical, Community, Policy/Systems
B. Evidence-based treatments
   Access to care
   Achievements of goals
   Consistent policies state to state
   Access to medications
C. Know it works
   Needs sustainability

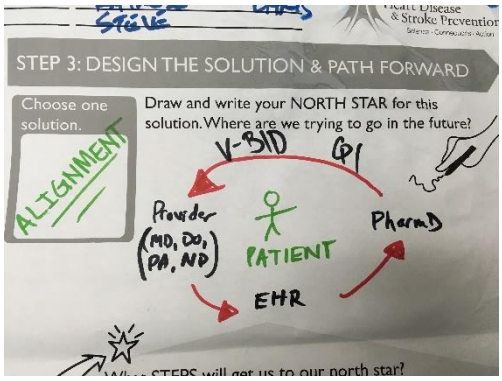
Step 2

- Alignment of payors and stakeholders
- Payment models and practice including CPA's
- Integrated vs. community Rx
- How we share data
- Transparent DIR
- Quality improvement
    - Public awareness
    - More process measures

Step 3

What steps will get us to our north star?

- Aligned payment model
- Public awareness
- Sate sharing, 2-way
- Standardize Q1 process



Resources
- Payors
- Providers
- Pharmacists
- Policy(makers)
- Community leaders
- Employers

Learn more about
- How do we data share
- Partner with aligned state and national DRG's

Need from CDC
- Connections to key stakeholders

Public Awareness

Step 1

A. Clinical, Community, Policy/Systems, Environmental
B. Public media release
   ABC^2DE
   Stories- KIS
   Events- run/walk
   - Scientific progress
   - Hope 4 ALL of us
   - Food as medicine
C. Media
   Internet
   Apps

Step 2

- Lifestyle
- Celebrity, actors, chefs
  - Rachel Ray
- Athletes- NBA, MLB, MLS, NHL
  - Ethnic dash diets
- Sandberg- Facebook, Apple, Google
- Music
- Funding
- CDC- Surgeon General

- 1-800-healthy
- AHA, AMA, ACC, NMA
- Media experts
- National Days

Step 3

Million hearts: 1 at a time

Hope

What steps will get us to our north star?

This is a journey

Resources	Learn more about	Need from CDC
-Media experts	- PR focus group testing	- Call to action! - Media spark

Clinical Decision Support

Step 1

A. Clinical and Policy/Systems
B. Making actionable information available, in real time, to the care team, that reduces burdens in treatment decision-making
C. 80% control in reach
   Date needs/interoperability are critical to success
   Crucial to involve many stakeholders in CDS development

Step 2

1. Need for standardization of data models and standards
2. Integration of many streams of data (HER, pharmacy, costs, etc.)
3. We need unique ID and ability to link disparate data sources and across borders
4. Most incorporate local stakeholders and end-users in design

Step 3

Integrated, High quality, data necessary for HTN management and control (BP, me use, costs…)

What steps will get us to our north star?

1. More out of office monitoring
2. Minimal-burden transmission of data
3. Business models to support sharing of data; alignment of incentives

Resources	Learn more about	Need from CDC
- IT/informaticists (no vendors) - End users, patients	- Successful implementations of CDS/factors in successful implementation	- Leadership + coordination in ensuring quality

Appendix VI

Sector-Specific Actions Activity Notes

Academia/Research

- Shift from discovery to implementation/translation
- Using implementation science to make sure translation of evidence-based care reaches populations most in need (Improve, not exacerbate, disparities.)
- Need for partnership/teamwork with other sectors
- Need for tailored research in specific populations
- Greater knowledge in healthcare economics
- Policy changes/advocacy – step out of comfort zone
- Tackle issues related to access to screening/treatment (lifestyle and drugs)
- Working with communities where academic centers are located. Regional thinking/collaboration. (Example: Right Care in South Dakota)
- Testing of combo pills – effects on adherence, side effects, BP lowering. (Gummy bear "pills" – chewable)
- Comparative effectiveness research on multifactorial interventions

Health Care/Clinicians

What resonated most with you?

- Identifying high value care with regards to hypertension
- Importance of multi-disciplinary teams
- Use of pharmacists as practitioners to improve hypertension outcomes
- Need for improved community education, especially engaging the youth and peer to peer messaging
- Ensuring patient engagement and empowerment
- Shared decision making
- Expansion beyond the usual care team to others like community health workers
- Need to better use payor data to support new models
- Shift to community-based care

What ideas did you feel best build on the momentum and groundwork that your sector/discipline has established?

- Continuing education on patient blood pressure monitoring
- Community health workers to be patient-centric not disease-focused
- Better job of writing evidence-based guidelines
- Providing additional avenues for patient engagement and interaction beyond the offices
- Family engagement
- Alignment of incentives to promote quality outcomes, including care teams.
- Involvement in Million Hearts
- Sticking to what we know is easy and works well

NGOs

What resonated most with you?

- CDC's commitment to a call to action and a roundtable
- The convening of multi-sector stakeholders; we can't do it alone, must come together. This meeting helped.

What ideas did you feel best build on the momentum and groundwork that your sector/discipline has established?

- PDSA process
- Dissemination partners
- Convening
- CDC convene/archives
- Evaluate process
- Building champions – storytellers
- Keep dissemination partners connected
- Collaboration is different in all communities
- Identify functions and outcomes communities need to be successful
- Building champions – pastors
- Spirit of the heart community/community health advocates to increase access
- Momentum
- CDC self-evaluate the process
- Having stories to tell/build champions
- Focus
- Collaboration is different in every community
- Identify outcomes and functions, competencies, or community leaders needed to deliver outcomes
- Role of NGO = convene or co=convene
- Reimbursement, especially for the uninsured, must include the community and individual
- Building the competency of community and adequately resource the partner

Payers

- Develop innovative category of preventive benefits
- New payment models for medicate therapy management services
- Improve wrap-around services to enhance patient experience (transportation, convenience, reminders, engaged working with community-based partners e.g., providers, community health workers, pharmacies.
- Coordination among plans for common formulary of anti-hypertensives

Pharmacy

What resonated most with you?

- Alignment of incentives
- Multiply pharmacy practice models
- Have a non-pharmacy group advocate for pharmacy provided services

What ideas did you feel best build on the momentum and groundwork that your sector/discipline has established?

- Pharmacy on roundtable board
- Establish bi-directional communication
- Payment model to support service
- Developing trusting relationships with providers
- Hitch hypertension to adherence

State Public Health

- Medicaid partnership
    - PMPM -> funding for public health
        - Team-based care/high-risk case management
- Community health workers
- Collaborative practice agreement
- Non-traditional public health team-based care
- Employer wellness programs
    - Link with public health
- Non-traditional funding

Appendix VII

Postcard Commitments

- Am committed to enabling hypertension to have a voice. We will incorporate hypertension in to one of our key corporate strategies.
- Commitment: to stay connected with a purpose to Larry Wu and RN Medicaid person…
  One Action: year of the horse and HTN card. Conned with Piedmont Hospital.
- Marti- The HTN Summit is wrapping up and we're tasked with writing down our action. NACDD will help with planning the net steps for Hypertension Consortium. Glad you will be involved. Thanks, Miriam
- 1. Commitment/Action: develop relationships with community pharmacy colleagues, looking for opportunities for collaboration on HTN.
  2. Strategy proposed: Broaden reach of community pharmacy in HTN management locally.
- 1. Add to consortium
  2. Follow-up contacts
- Engagement. Susan B. Komen model connect Big Tech pay to not play
- 1. Work on the use of Community Health Workers in our Health System
  2. -Research the ROI
  -Get in Touch with Carl Rush
- What is commitment/strategy that you would like to pursue?
  *AMWA to assist in planning round table. What is 1 action that you can take on the next 3 months to move this pursuit forward?
  1. Charge AMWA Preventative Taskforce to take this on
  2. F/u with team and remind CDC of our interest
- -Sign up for round table
  -Reconnect with Heart Association on driving the work together on hypertension
- -go with Betsy to work on hypertension forum
  -present ideas for including hypertension in 2020 strategy at PHI
  Work on getting Bethene model implemented across CA with Haddie and Right Care
- 1. Great implementation and adoption of team-based care with pharmacists
  2. Will work to connect leadership of national pharmacy organizations to the council
- 1. Continue to build strategic partnerships to bring healthcare to employers/private sectors.
  -eliminate obstacles-
  2. Work with BPfirst/CDC Foundation to build a sustainable MTM for Engineered Floors and North Georgia Area
- -BP pt. self-monitoring
  -NMA- Be a member of the consortium
- 1. Commitment/Strategy: provide leadership and expertise to the goal of 80% HTN control
  2. Action in next 3 months: work more closely with CDC DHDSP/MH
- -Align incentives for BP control
  -Make the follow-up for this meeting happen
- 1. Implementations of evidence-based practices

2. Don't let perfect be enemy of the good

3.Regional Collaboration

- 1. Join the CDC roundtable
  HTN Commitments:
    - If asked, 1-800-Healthy, HTN coaching
    - Need publica airways campaign of Hope
    - Million Hearts/family stay at a time
    - Mentoring by high performers really matters (not just best practices sharing)
    - Kindred spirits acting together are much more powerful
    - CQI Right Care Coalition building PDSA
- 1. Dissemination of information to Association of Black Cardiologists/ Join national planning committee/ Round table as Association of Black Cardiologists Representative
  2. Join CDC National Planning Committee on Hypertension Control
- Strategy: NACHW will serve as a resource to ongoing leadership group (taskforce) for this initiative
  Action: assemble list of currently available toolkits for employers of CHWS
- Commitment: launch partnership through CDC 1817 Wellness Grant engaging health plans in value-based payment to pharmacists in to community for HTN management.
  Action: above and willing to serve on any CDC round table boards etc.
- - System wide goal around HTN control
  - CHW organization HTN control training
  - Reach our to North Carolina BC leader to develop statewide initiative
  - Determine Georgia contact to initiate statewide collaboration to improve BP control
- -Growing target BP
  -Working on team-based care
- Commitment/Strategy to pursue: Influence organization to take on 7 implementation research
  One action to take in the next 3 months: Integrate idea into 2020-2022 strategy plan for organization
- 1. Commitment- join the consortium
  2. Will pursue the communications strategy with creativity
- 1. Explore drafting templates for contractual agreements in states with Medicaid Managed Care to set hypertension control benchmarks
  2. Have ASTHO joint the hypertension round table
- - BP collaborative
  - BP support group
  - Meeting w/ KW
  - Get data
  - Research funding
- Once action to move HTN agenda forward
    - Promote use of algorithm in primary care practice
    - Better use of CHWS to promote HTN control
- 1. Low value to high value to better engage payors?
  2. Greater collaboration with partners
- Under V+A umbrella, converse providers, payers and others to rapidly drive lowering of OOP costs for HTN meds and bring uniformity to formularies.

- Dear CDC Hypertension Control Meeting,
  I would like to introduce the New York City Hypertension Initiative led by Sonia Angel to the CDC Program similar goals exist between these two initiatives.
  Best, Stephen
- 1. Commitment to Pursue- get blood pressure measure correctly
  2. One Action Next 3 Months- Engaging other providers to commit to looking at getting Blood Pressure down to help get to 80%
- 1. Would like to explore collaborative practice agreement with community pharmacists.
  2. Reach out to Arkansas Pharmacists Association, and a community pharmacist champion.
- Strategy:
  -Build disseminate networks among partners to share best practices, resources, and stories
  Action:
  -Invite network to target BP newsletter
  -Invite speakers to Target BP webinar on key topics- tear-based care (PA, SMBP)
- Dear CDC Hypertension Control Meeting,
  My second letter is to let you know that I will also connect you with CDC which is Clinical Directors Network which is a not-for-profit clinician membership practice-based research network. Their focus us clinical translation.
  Best, Stephen
- 1. Pursue incentives for Heath X X to improve hypertension with HRSA BPHC.
  2. Develop a communications strategy
  Much at HRSA BPHC to discuss hypertension control in a quality award.
- - Gain better understanding of how better BP managements can be integrated into self-management
  - Reach out to at least one of these ongoing studies and/or payers for deeper discussion.
- Fight towards >80% HT points cut target…
  Check every outpatient and BP level and intervene if needed
- Commitment/Strategy to Purse: Work with local MD org. to measure awareness of BP
  Action to Take On: expand the Right Care Initiative to include local and more awareness

Appendix VIII

Idea Wall Notes

- We need patients/patient groups involved in these discussions.
- Association of Black Cardiologists – Culturally tailored and appropriate patient information
- Seven Steps to a Health Heart
- Why children should know their grandparents (youth/children version of Seven Steps to a Healthy Heart)
- Focus on social determinants of health
- Association of Black Cardiologists – Community health advocates
    - Has been successful in using health advocates to encourage healthy lifestyles
- Grady Health System, Atlanta has a successful population health program that tracks social determinants of health and provider/clinic level in