Key Findings and Lessons Learned from the 2023 Million Hearts® Health Equity Implementation Project

Prepared by:

Laura Warner, MD, MPH
Susan Svencer, MPH
Julia Schneider, MPH
Brittaney Bethea, MPH
NACDD Cardiovascular Health Team

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
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Million Hearts®

Key Findings and Lessons Learned from the 2023 Million Hearts® Health Equity Implementation Project. Atlanta, GA: National Association of Chronic Disease Directors; December 2023.

The National Association of Chronic Disease Directors' (NACDD) Million Hearts Project is supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award fully funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by CDC/HHS or the U.S. Government.

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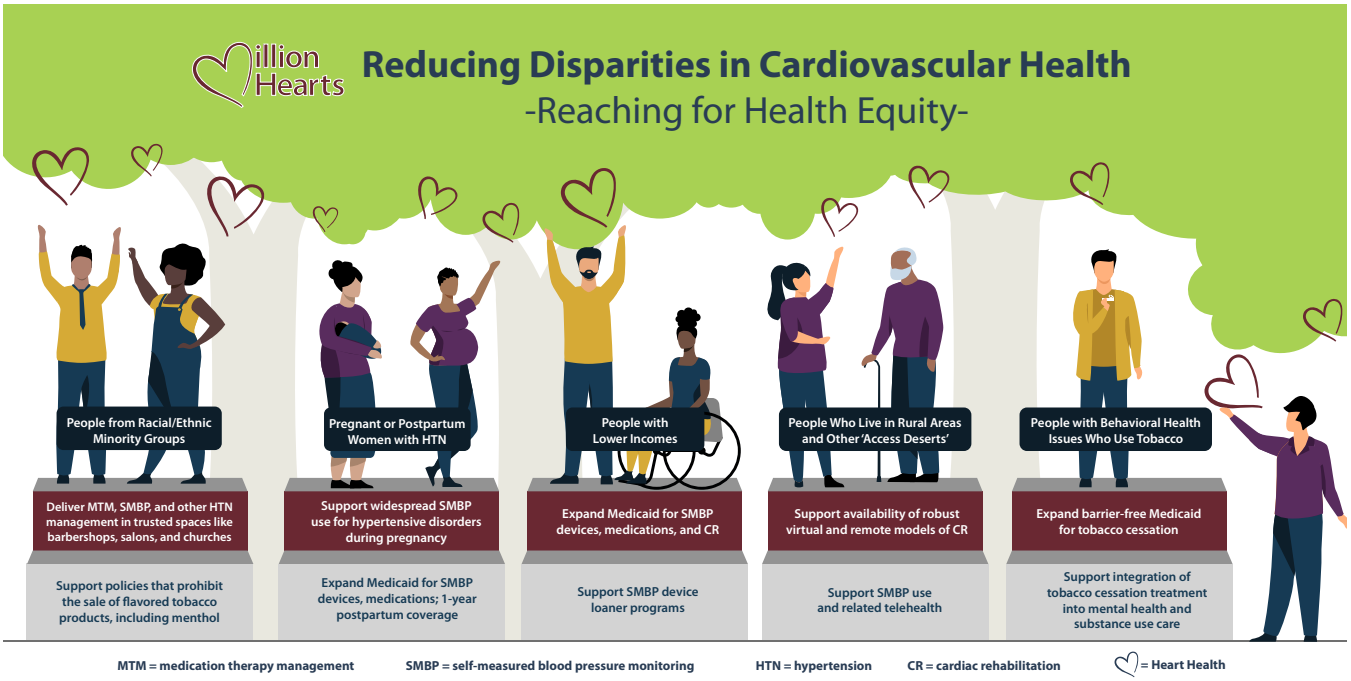
Introduction

The National Association of Chronic Disease Directors (NACDD), in coordination with Million Hearts® (a national initiative co-led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services), invited organizations from across the United States to apply for Health Equity Implementation funds in late 2022 through a Request for Proposals (RFP) process. The intended purpose of the funded projects was to improve cardiovascular health through a focus on health equity, with each applicant identifying a Million Hearts® priority population and Million Hearts® strategy to address their needs.

NACDD received over 100 applications for the Health Equity Implementation funding, spanning almost every US state and the entire spectrum from urban to rural settings. The most commonly proposed strategies for reducing inequities in cardiovascular health were Self-Measured Blood Pressure (SMBP) Monitoring, Cardiac Rehabilitation, and Tobacco Cessation, and all priority populations were represented in the applications. The large number of applications is a testament to the urgency of improving equity in cardiovascular health regardless of population or setting.



As 2022 drew to a close, six organizations were selected for funding, and each received up to $50,000 to implement their project from January through July 2023. The funding recipients represented a wide range of geographies, organizational types, and innovative ideas for utilizing Million Hearts® strategies to positively impact the health of a priority population.

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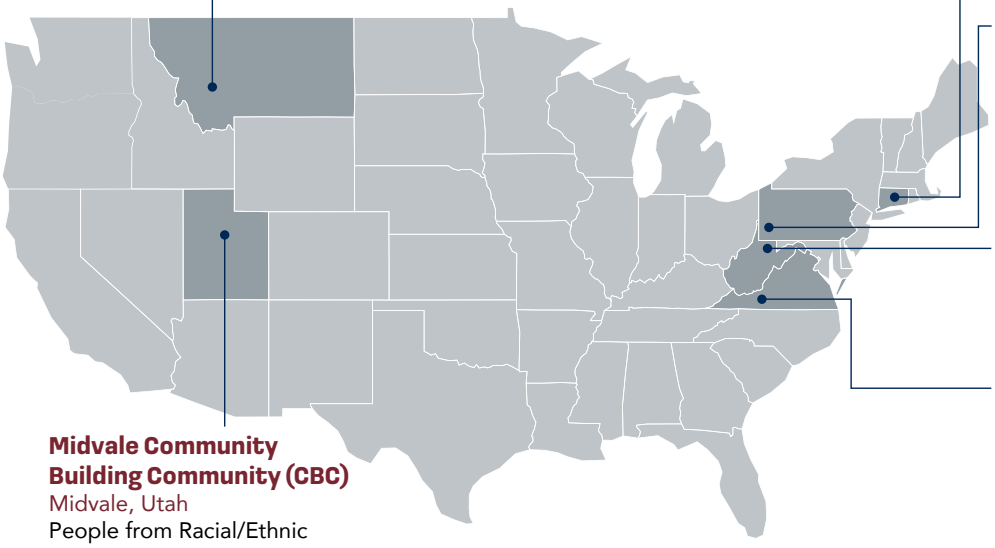
Funded Organizations and Priority Populations



St. James Healthcare
Butte, Montana
People Who Live in Rural Areas and Other 'Access Deserts'

UConn Health Maternal-Fetal Medicine
Farmington, Connecticut
Pregnant or Postpartum Women with Hypertension

University of Pittsburgh / Pennsylvania Pharmacists Care Network (PPCN)
Pittsburgh, Pennsylvania
People with Lower Incomes

West Virginia University School of Pharmacy
Morgantown, West Virginia
People Who Live in Rural Areas and Other 'Access Deserts'

Huddle Up Moms
Roanoke, Virginia
Pregnant or Postpartum Women with Hypertension

Midvale Community Building Community (CBC)
Midvale, Utah
People from Racial/Ethnic Minority Groups / People With Lower Incomes

Project Team Milestones

Date	Milestones
January 2023	• Contracts initiated • Project team meetings with NACDD consultants and members of the Million Hearts® team, revisions to implementation plans • Project work initiated
January-July 2023	• Monthly check-in meetings between project teams, NACDD and Million Hearts®
March 15, 2023	• First virtual meeting of all project teams to share progress and discuss challenges
April 15, 2023	• Mid-point progress reports submitted
May 25, 2023	• Second virtual meeting of all project teams
July 2023	• Most project work complete, with some implementations extending beyond July 31 • Virtual celebration featuring results and outcomes from all project teams o Included representatives from Million Hearts®, NACDD, and cardiovascular health staff from State Health Departments o View a video recording of the meeting here: https://chronicdisease.org/page/cardiovascularhealth/mhhei/
August 31, 2023	• Final reports submitted
September 19 and December 6, 2023	• Project team check-ins with NACDD and Million Hearts® to share progress on spread and sustainability

Pregnant or Postpartum Women with Hypertension

UConn Health

Summary

UConn Health's Maternal-Fetal Medicine practice supplied pregnant and postpartum women at risk for hypertensive disorders of pregnancy with a Preeclampsia Foundation Cuff Kit and blood pressure (BP) monitoring education. The practice serves a large proportion of low-income women. The project also offered providers the option to refer women for a telehealth visit with a pharmacist to promote medication adherence.

Major Activities

- Developed Epic workflows for inpatient and outpatient settings to support documentation and tracking of program participation, and to facilitate communication among care team members.
- Epic reports tracked which patients received a Cuff Kit, cuff size, and that education was provided, as well as the number of tele-pharmacist referrals.
- Providers and clinical staff received education on the program via in-person, Webex, email, Epic Tip Sheet, and Epic newsletter formats.
- The project team worked with the Department of Social Services (state Medicaid payer) to ensure that the managed Medicaid quality metric for high-risk maternal women to receive SMBP would be satisfied even though a Medicaid claim for SMBP was no longer submitted as a result of this program.
- The pharmacy department has applied to be a contracted vendor for Medicaid and other payers to dispense SMBP. If approved, this will allow for reimbursement for SMBP in cases where it is a covered service. Additionally, the UConn Foundation has been approached for support to cover SMBP in cases where it is not a covered service.

Outcomes and Results

- 212 patients enrolled: 60 inpatients and 152 outpatients.

Enrolled patient race/ethnicity	Number of enrolled patients
American Indian or Alaskan Native	2
Asian	7
Black or African American	72
Hispanic or Latino	55
Other	5
Unknown	3
White	68

  - Enrollees received Cuff Kit; education on the importance of SMBP, BP cuff assembly and use; access to Preeclampsia Foundation's *Your Blood Pressure Check *Know* Share* educational tool via Epic MyChart.
  - 65% of enrolled patients used a standard size Cuff Kit and 35% used the large size.
- Pharmacist referrals were offered to all enrollees, but none took advantage of it.
- 6 enrolled patients referred to the Women's Health Community Health Specialist, who provided resources to address food, housing, transportation, energy assistance, childcare, and parenting strategies.
- Staff expressed a great deal of satisfaction from the ability to provide no-cost Cuff Kits at the point of care to patients who need them. They relayed those patients received better education with the Cuff Kits in hand and that staff time was spent more efficiently.

UConn Health

Lessons Learned

- There was less need for pharmacist consults than anticipated. Providers and nurses provide extensive education on aspirin and anti-hypertensive medications, which may have eliminated the need for further patient consultation with a pharmacist.
- The initial contracting process to receive the grant funds took several weeks, so the project team made good use of that time by preparing the Epic workflows and educational materials needed for the program. They were ready to launch quickly once the contract was fully executed.
- At times there are delays in shipping for Cuff Kits, leading the project team to be prepared for inconsistencies in availability of some cuff sizes. It was initially difficult to predict the need for standard versus large cuff sizes and the team adjusted by placing orders with plenty of lead time and ensuring adequate stock of both sizes.

Patient Success Story

A patient noticed high BP and an increased heart rate while using her Cuff Kit at home despite taking her anti-hypertensive medication as prescribed. She felt unwell and went to the Emergency Department for evaluation, where she received intravenous BP medication and her symptoms resolved. She was discharged home with a different anti-hypertensive that was a better fit and she continued on to have a normal pregnancy without further complications.

Key Relationships

- Engaged physician leader – input on electronic health record workflow development and support for the project when challenged by new users was critical for full program implementation.
- Epic analysts – documentation and data capture through the electronic health record were essential to success.

See the Appendix for a link to online access to UConn Health's electronic health record workflows and provider educational materials.

Pregnant or Postpartum Women with Hypertension

Huddle Up Moms

Summary

This community-based organization provided Preeclampsia Foundation Cuff Kits and care navigation to underserved pregnant women. The women engaged in an education and monitoring program with a care coordinator, who also connected them to community resources to address social determinants of health (SDOH)-related needs. Other local community-based organizations and clinical partners were encouraged to refer pregnant women to the program.

Major Activities

- Program Director/Care Coordinator hired in January 2023.
- Pre- and post-educational survey developed to measure participant knowledge of pregnancy-related hypertensive disorders, self-confidence, self-efficacy in SMBP, and willingness to self-advocate.
- Registration survey developed to gather information on SDOH-related needs of participants.
- All program materials translated to Spanish by partner organization, Casa Latina.
- Social media campaign created to raise awareness of the program and provide information on hypertensive disorders of pregnancy.
- Partnerships with community-based organizations and local clinicians were built to encourage referrals for program enrollment.
- Project leaders are exploring further connections with local and state partners, including the Carilion Clinic and the Virginia Department of Health, to sustain and spread elements of the program to other rural areas of the state.

Huddle Up Moms

Outcomes and Results

- 17 participants enrolled to receive a no-cost Preeclampsia Foundation Cuff Kit and regular follow-up communication via text, phone call, or email from the Care Coordinator.

Self-reported race/ethnicity	Number of participants
Black	1
White	6
Hispanic, non-White	6
Jordanian	1
Black, American, Indian, White	1
White and American	1
African American and White	1

- Participants enrolled independently online, in person at the Huddle Up Moms location, or were referred from a community partner.
- Project team outreached community members at six events, including a Women's Resource Summit hosted by Huddle Up Moms.
- 75 Cuff Kits distributed to community partners to utilize in recruiting future program participants.
- Results from post-educational surveys are pending delivery of participants' infants.
- This program and its link to the Preeclampsia Foundation's resources represented a significant expansion of the types of services offered by Huddle Up Moms, which had not previously supported participants with clinical resources.

Lessons Learned

- Establishing communication and partnerships with local clinicians required persistence and emphasizing the value of the program to improving maternal health outcomes.
- Participant enrollment was slower than anticipated, which the project team addressed by raising awareness of program benefits, building trust with the community, and addressing barriers to enrollment by expanding eligibility criteria.
- Current events that are a part of the national conversation can present opportunities to raise awareness of issues impacting health and health equity. Huddle Up Moms incorporated maternal-health related current events into their social media campaign to connect with pregnant people and their loved ones.
- The process for community and clinical partners to refer women for program enrollment was tailored to each organization to minimize staff burden and optimize effectiveness.

Patient Success Story

As a pregnant woman was being taught to use the SMBP device from a nurse conducting a home visit, it was noted that she had very high BP. The mother already had concerns about the health of her pregnancy and, after feeling dismissed by other providers, willingly took the nurse's recommendation to seek immediate care. This action resulted in an emergency delivery and resuscitation of the infant. Mom and baby have now recovered and are grateful for the BP Cuff Kit and the nurse's care.

Key Partnerships

- Casa Latina
- Child Health Investment Partnership (CHIP) of Roanoke Valley
- Healthy Families Roanoke Valley
- The Motherhood Collective
- Carilion Health System
- LewisGale Physicians Midwifery

See the Appendix for a link to online access to Huddle Up Moms' social media campaign messages.

People Who Live in Rural Areas or Other "Access Deserts"

West Virginia University School of Pharmacy (WVU)

Summary

The WVU Medicine Heart Failure clinic expanded a pharmacist-led telemedicine heart failure medication optimization program internally and at selected primary care clinics in the West Virginia Practice-Based Research Network. BP cuffs and scales were provided to adult patients in rural Appalachian areas. The project aimed to reduce barriers to specialty care access; improve the percent of heart failure patients receiving appropriate medications; and improve heart failure symptoms, quality of life, cardiac function, and mortality.

Major Activities

- Provider education plan developed and implemented to raise awareness of the project and encourage referrals.
- System created to track distribution of BP cuffs and scales.
- Tele-pharmacy workflows and follow-up protocols developed and implemented.
- Project implemented at WVU and partner sites.
- Preliminary results from this project were presented at a state meeting to increase awareness of the effectiveness of tele-pharmacy medication optimization for heart failure patients.

Outcomes and Results

- 172 patients enrolled with mean age 64 years.

Demographic characteristic	Number of enrolled patients
Sex: Male	120
Female	52
Race: White	167
Black or African American	5
Insurance status: Medicaid	28
Medicare	115
Commercial	25
Uninsured	4
Rural residence	50

- All enrolled patients received a BP cuff, and 25 additional BP cuffs were distributed to Community Care of West Virginia for future use by patients.
- 100 scales distributed to enrolled patients.
- Clinical sites participating in the program include 7 sites at Community Care of West Virginia and 4 sites at WVU Medicine (Ruby, Bridgeport, Summersville, and Wheeling).
  - o 118 patients enrolled at WVU sites and 54 at partner sites.
- 144 tele-pharmacy visits were provided to enrolled patients.
- Enrolled patients completed the Kansas City Cardiomyopathy Questionnaire upon and after enrollment. Aggregated results are still pending as patients continue to receive tele-pharmacy care.
- Data and learning from this project are informing the integration of technology into a multi-disciplinary telemedicine model at WVU and advocacy efforts for West Virginia Medicaid to cover the cost of SMBP cuffs for beneficiaries.

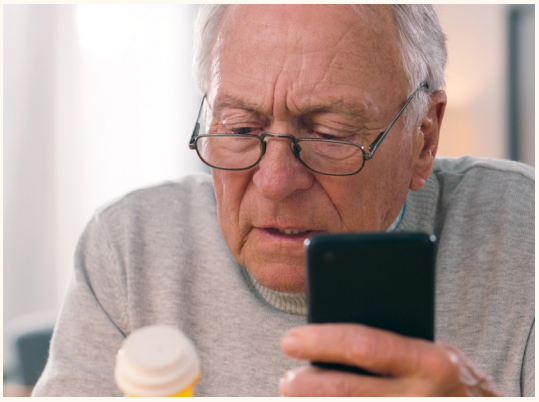
West Virginia University School of Pharmacy (WVU)

Lessons Learned

- Inclusion criteria for enrollment eligibility were adjusted during the project period to include all heart failure types, rather than only heart failure with reduced ejection fraction as originally proposed. This change was made to simplify and encourage program referrals.
- Reaching rural patients was primarily accomplished through referrals from Community Care of West Virginia and through heart failure outreach clinics in Summersville and Bridgeport.
- Not all BP cuffs come with batteries included. The project team adjusted their budget to purchase batteries so that patients would receive fully functional cuffs.
- There was a need for extra small BP cuffs that was not anticipated since this size is primarily used for pediatric patients. The team was able to purchase extra small cuffs from an online medical supplier to use for adults with small arm circumferences.
- Approximately 50-75% of enrolled patients did not have access to a scale at home. Extra scales were purchased during the project period to account for the high demand.
- Internet access was difficult for a large proportion of patients living in rural areas. As a result of this, remote electronic consent for participation in the project was not possible for many enrollees. Instead, they gave consent over the phone or in-person at a variety of clinical sites.

Patient Success Story

A patient with newly diagnosed heart failure after hospital admission for a heart attack was discharged home with a new medication regimen. As he followed up via tele-pharmacy over the course of 3 months, his medications were adjusted to optimize symptom management and clinical metrics. These changes led to significant improvement in his quality of life and symptom control.



People Who Live in Rural Areas or Other "Access Deserts"

St. James Healthcare

Summary

This rural hospital serving a 7-county region in Southwest Montana provided BP cuffs and scales to patients admitted with a diagnosis of heart failure, with an emphasis on residents of rural areas. Participants received education on their diagnosis, medications, and use of the cuff and scale. A pharmacist and a Cardiac Rehab Therapist also followed up with participants after hospital discharge and coordinated with the care team as needed.

Major Activities

- Patient education plan developed. All enrollees received congestive heart failure-focused education from the hospitalist, pharmacy, and nursing teams.
    - o Education included diet, exercise, fluid and salt intake, self-weighing, at-home BP monitoring, and medications/medication management.
- System created to track distribution of BP cuffs and scales.
- Electronic health record workflows created to monitor participation by and care team follow-up with patients, and to automatically refer patients to Cardiac Rehab.
- Care team protocol developed to follow up with patients reporting significant changes in BP or weight. Follow-up occurred via phone and led to prompt clinic visits when warranted.

St. James Healthcare

Outcomes and Results

- Twenty patients enrolled with an age range of 31-86 and the following additional demographics:

Demographic characteristic	Number of enrolled patients
Sex: Male	15
Female	5
Ethnicity: Caucasian	19
Hispanic	1
Insurance status: Medicare	14
Medicaid	3
Commercial	2
VA	1

- Patients submitted data on SMBP (twice daily) and weight (once daily) for 60 days through the following channels:

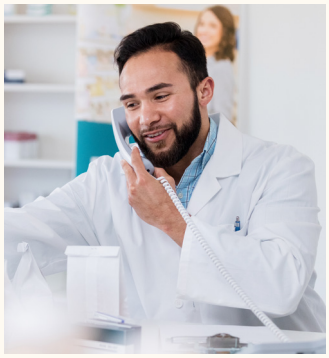
Communication channel	Number of enrolled patients
Cardiology or Clinical Pharmacy	10
Paper log	6
MyChart HF flowsheet	4

- Three of the 20 enrolled patients were readmitted to the hospital during the project period for congestive heart failure symptoms.
  - o One enrolled patient passed away from cardiac arrest during the project period.
- Significant decrease in 30-day all cause hospital readmission rate for enrolled patients:
  - o 35% at beginning of project period; 0% for final 2 months of project period.
- Three patients participated in St. James Healthcare Cardiac Rehab and 2 participated in local YMCA Cardiac Rehab.

- Observed increased interest and participation in Cardiac Rehabilitation as patients received more education and had a better understanding of their medical condition. As a result, St. James Healthcare is exploring expansion of Cardiac Rehab services and the hospital's affiliated Foundation is supporting this growth along with fundraising to purchase additional SMBP monitors and scales.
- Exploring program model expansion to additional parts of the hospital system's service area as well as to other chronic medical conditions.

Patient Success Story

During a follow-up phone call to an enrolled patient with a new diagnosis of congestive heart failure, a pharmacist learned that the patient was confused about one of his new medications. The hospital care team started the patient on a new medication to help control heart failure symptoms, and he was considering discontinuing use of the medication because he thought it was a duplicate of another medication he was taking. The pharmacist was able to educate the patient on the importance of both medications and prevent a possible worsening of symptoms.



Lessons Learned

- The project team adjusted the patient recruitment strategy during the project period due to a slow start to enrollments:
  - o Geographic reach of the program was expanded to include non-rural residents with housing and transportation challenges.
  - o Patient recruitment area was expanded to include high-risk individuals from outpatient cardiology.
- Remote patient monitoring was initially proposed to follow patients' BP and weight data, however this was no longer an option upon project launch. The team developed alternative workflows to allow patients to submit data either through an electronic health record portal or manually via paper log.
- Training patients in use of the electronic health record portal for tracking BP and weight data was time intensive, resulting in additional members of the care team being brought in to share the responsibility of training patients and answering questions.

See the Appendix for a link to online access to St. James Healthcare's electronic health record workflows, and patient and provider educational materials.

People From Racial/Ethnic Minority Groups / People with Lower Incomes

Midvale Community Building Community (CBC)

Summary

This charitable clinic serving low-income, uninsured Latino patients supplied BP cuffs to patients with hypertension (HTN) and screened adults served in their mental health and dental programs for tobacco use. Community Health Workers (CHWs) provided education, follow-up, and connections to community resources. Midvale CBC also subscribed to the Dispensary of Hope, enabling the clinic to provide free medications to patients at the time of their visit.

Major Activities

- Community Health Workers (CHWs) identified program participants, provided BP and SMBP monitoring education, and followed up with enrolled individuals via phone, text, and in person to encourage submission of BP tracking logs.
- Newly established weekly Hypertension Clinic to provide ongoing follow-up for patients.
- Charity Pharmacy license established through the Utah Board of Pharmacy.
- In-clinic pharmacy policies and procedures developed to allow real-time access to anti-hypertensive and tobacco cessation medications to enrolled patients.
- 10 BP cuffs reserved to loan to patients for future SMBP monitoring.

Outcomes and Results

- 150 SMBP cuffs distributed to program participants:

Demographic characteristic	Number of SMBP program participants
Ethnicity: Hispanic or Latino	150
Sex: Male	33
Female	117
Age: 20-40	53
40-60	75
60-80	22

- 81% of BP tracking logs returned as of November 30, 2023.
- All patients with new or uncontrolled HTN were referred for follow-up care with their primary care provider or at Midvale CBC's weekly Hypertension Clinic.
  - o Thirteen patients were prescribed medications for HTN or tobacco cessation.
  - o Twenty-seven prescriptions for hypertension medications were provided at no charge to patients through a clinic subscription to Dispensary of Hope.
  - o Many patients have been connected to additional services, such as diabetes education classes, through visits to the Hypertension Clinic.
- CHWs administered a tobacco use survey at Midvale CBC's weekly food distribution day, local wellness fairs, and other community events to identify individuals interested in referral for tobacco cessation resources.
  - o Outreach was conducted at 13 local wellness fairs and community events.
  - o 341 clients screened for tobacco use and interest in cessation supported.
  - o Physicians provided tobacco cessation services to interested individuals.
  - o Over 500 individuals received information on BP and HTN.
- More than 300 community members received information on tobacco use.

Midvale Community Building Community (CBC)

Lessons Learned

- Patients often underestimate or do not recognize the importance of BP control and submitting their BP logs. CHWs spent time following up with patients to obtain completed logs. The clinic asked patients to sign a Social Contract to establish expectations for returning their BP logs upon program enrollment.
- There is a great deal of misinformation and misunderstanding in the Latino population about the importance of BP control and the need for early evaluation and treatment to prevent negative health impacts. More ongoing education is needed.
- Many tobacco users experience shame and are reluctant to seek cessation services. Engaging these individuals in motivational interviewing is more successful than a survey alone when offering cessation support.

Key Partnerships:

- University of Utah School of Medicine
- University of Utah College of Pharmacy
- Dispensary of Hope
- Canyons School District
- AeroStar Media
- Latinx Coalition
- Mexican Consulate
- Utah Food Bank
- Alliance Community Services
- Comunidades Unidas
- University of Utah Wellness Bus
- YMCA of Northern Utah

Patient Success Story

A client was offered a BP cuff for herself after inquiring about a cuff for her father. After reluctantly accepting, she began tracking her BP and learned it was dangerously high on a regular basis. She made an immediate appointment with her doctor to begin treatment and is thankful she was encouraged to participate in the program.

See the Appendix for a link to online access to Midvale CBC's Spanish-language clinic forms and patient outreach materials.

People with Lower Incomes

University of Pittsburgh / Pennsylvania Pharmacists Care Network (PPCN)

Summary

PittPharmacy and PPCN supported teams serving low-income patients with hypertension at five pharmacies in underserved areas of the state. A pharmacist champion and intern at each site identified Medicaid patients to receive services including, but not limited to, 1) BP screenings and follow up; 2) medication adherence support; 3) BP medication therapy management; 4) care coordination; 5) lifestyle modification counseling; 6) SDOH screening and linkages to resources.

University of Pittsburgh / Pennsylvania Pharmacists Care Network (PPCN)

Major Activities

- Project team utilized a Geographic Information System (GIS) to identify independently owned pharmacies in areas with high or moderate-to-high overall, socioeconomic, and racial and ethnic minority social vulnerability on the CDC/ATSDR Social Vulnerability Index. Of these pharmacies, five were recruited to implement this project.
  - o Each pharmacy's project was led by a pharmacist Practice System Champion and a pharmacy student Intern.
  - o Recruited pharmacies were located in Luzerne, Lehigh, Philadelphia, Delaware, and Berks Counties.
- Participating pharmacies received technical assistance to develop customized internal processes and procedures for the following activities:
  - o Identifying patients eligible for services.
  - o Providing hypertension services (e.g., medication counseling, reconciliation, synchronization).
  - o Documenting care provided (i.e., through an eCare plan submission and a patient encounter survey unique to this project).
  - o Ensuring appropriate follow-up care for patients through handoffs to local clinicians.
  - o Screening and referral for SDOH-related needs.

Patient Success Story

A woman with uncontrolled hypertension had her blood pressure brought to control with the assistance of a community pharmacist. The pharmacist helped her to obtain a home BP monitor and coordinated getting the results to her primary care doctor. Through a screening for social determinants of health-related needs the pharmacist was also able to connect her to employment and transportation resources in her area.

- Outreach to local providers occurred through in-person conversations and customized educational materials and letters.
  - o Pharmacies informed clinicians of their range of services offered and the opportunity to mutually care for patients.
  - o Bidirectional referral process between the pharmacy and physicians established in some cases. Physicians referred patients to the pharmacy for hypertension services offered through the program, while pharmacies referred patients to physicians for ongoing hypertension management when needed.
  - o Some pharmacy-clinic dyads created a process to obtain a prescription for home BP monitors for patients who would benefit. Pharmacies provided education on cuff use.
- Patient education materials adapted from published sources such as AMA and AHA/ACC, including instructions on home BP monitoring techniques, home BP logs, and information about available BP screening.
- Participating pharmacies were connected to each other through an online learning platform and regular check-in meetings to:
  - o Engage in discussions led by pharmacy subject matter experts on a range of topics.
  - o Share materials such as a pharmacist-provider collaboration toolkit and examples of patient service flyers and patient educational materials.
- During the project period, a statewide payer program to provide reimbursement mechanisms for patient services, like hypertension monitoring and SDOH screening, was launched.

University of Pittsburgh / Pennsylvania Pharmacists Care Network (PPCN)

Outcomes and Results

- 110 unique patients received hypertension services:
  - o 162 patient encounters captured among these patients.
  - o 32% of patient encounters were for follow-up care.

Demographic characteristic	Number of patients
Race: Black or African American	16
White	124
Other	1
Unknown	21
Ethnicity: Hispanic or Latino	3
non-Hispanic or Latino	107
Unknown	52
Insurance status: Medicaid	153
Underinsured	5
Uninsured	1
Other	3

- 73 screenings conducted for SDOH-related needs:
  - o 13 referrals for SDOH resources accepted.
- 26 BP cuffs provided to patients at no cost through a prescription and insurance claim.
- Four interns and three preceptors attended an in-person BP training. Those who were unable to attend completed online BP training modules through the American Heart Association and the American Medical Association.
- Three pharmacies held community outreach events.
- Project presented via a poster at the 2023 Pennsylvania Public Health Matters! People, Strategies, and Policies to Advance Healthy Communities conference in June 2023.
- Abstracts submitted to present project results at the National Community Pharmacists Association Annual Convention in

October 2023 and a continuing education presentation at the Pennsylvania Pharmacists Association Annual meeting in February 2024.

- The knowledge and skills gained in this project by the PPCN and participating pharmacies will be spread across the Network to provide support to others navigating rapid integration of pharmacy services.

Lessons Learned:

- It was easiest for pharmacies to identify Medicaid beneficiaries who might benefit from hypertension services through their dispensing software reports.
- Screening for SDOH-related needs was critical to pharmacies successfully removing barriers for patients seeking BP control.
- While a high percentage of patients receiving services through this project had lower incomes, project leaders would consider using census tract-level data rather than county-level data in the future to try reaching more people with lower incomes who are also a part of a racial or ethnic minority group.
- Support from Interns at each pharmacy was essential to implementing services and engaging patients. If interns were unavailable in the future for a similar project, a variety of other pharmacy team members could serve as project support.
- Implementing hypertension services required a large amount of pre-work by many pharmacies to develop necessary processes and procedures. Rather than aiming to reach perfection before beginning to engage patients, pharmacies were able to launch their programs with most pieces in place, then refine and evolve workflows as they gained experience serving patients' needs.
- Many pharmacies recognized that patients are often not aware of the full range of services available at a pharmacy. Strategies were shared among pharmacies to help engage and educate patients on what they can expect from their pharmacy.
- The Million Hearts® Hypertension Control Change Package was a key resource to guide pharmacies as they developed their internal processes and procedures.

See the Appendix for a link to online access to Pitt/PPCN's examples of pharmacy policies and procedures, patient outreach and education materials, and an online learning platform snapshot.

Conclusion

These six Health Equity Implementation projects show simple yet important ways that organizations can alter their services in an effort to improve access to the opportunities for better cardiovascular health. Each of these recipients helped people they served overcome some barrier – be it a cuff, a consultation, or a new service. These are real world examples of applying Million Hearts® health equity strategies in community settings. It can be challenging to envision how such strategies translate to serving the people from priority populations that are critical to reach, especially when the need to address long-standing health disparities is so urgent. The ability of these recipients to make meaningful, positive impacts on so many individuals in their communities in only seven months and with a relatively small amount of funding is reassuring and inspiring.

...the true power of these projects is their potential for wider spread and/or policy change.

There are many promising practices and lessons learned from the Health Equity Implementation that have led to system changes and policies among the funding recipients, however the true power of these projects is their potential for wider spread and/or policy change. With the knowledge gained from these projects, others will hopefully face fewer barriers and have access to more resources when attempting similar interventions. Building on the great work of others creates momentum for deeper impact with even small investments.

It is NACDD's hope that the information in these pages is utilized to advance cardiovascular health equity as widely as possible. Please apply what you have learned to your own role or share this report with a colleague who can take action. Together, we can make significant progress toward our goal of improving cardiovascular health equity.

Project Contacts

UConn Health Maternal-Fetal Medicine
Wendy Martinson, Ambulatory Quality Manager:
wemartinson@uchc.edu

Huddle Up Moms
Dr. Jaclyn Nunziato, Executive Director: jnunz24.hum@gmail.com

West Virginia University School of Pharmacy
Dr. Kazuhiko Kido, Clinical Associate Professor of Clinical Pharmacy:
kazuhiko.kido@hsc.wvu.edu

St. James Healthcare
Dr. Jennifer Davenport, VP/Chief Medical Officer:
jennifer.davenport@imail.org

Midvale CBC
Mauricio Agramont, Executive Director: magramont@midvalecbc.org

University of Pittsburgh / PPCN
Dr. Kelsey Hake, PittPharmacy Pharmacist Senior Program Manager and PPCN Director of Engagement: kelsey.hake@pitt.edu

Dr. Stephanie McGrath, PPCN Executive Director:
stephanie.mcgrath@pitt.edu

NACDD
healthsystems@chronicdisease.org

Acknowledgments

NACDD is grateful for the guidance and support of our Million Hearts® colleagues, including:

- Judy Hannan, Senior Advisor
- Jennifer Eisler, Public Health Analyst
- Marilyn Werner, Health Communication Specialist
- Nicole Therrien, Pharmacist, Division for Heart Disease and Stroke Prevention

Acronyms

AHA/ACC	American Heart Association/American College of Cardiology
AMA	American Medical Association
ATSDR	Agency for Toxic Substances and Disease Registry
BP	blood pressure
CBC	Community Building Community
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
HHS	U.S. Department of Health and Human Services
HTN	hypertension
NACDD	National Association of Chronic Disease Directors
PPCN	Pennsylvania Pharmacists Care Network
SDOH	social determinants of health
SMBP	self-measured blood pressure
WVU	West Virginia University

Appendix

URLs for online supplementary materials

- UConn Health Maternal-Fetal Medicine
- Huddle Up Moms
- St. James Healthcare
- Midvale CBC
- University of Pittsburgh / PPCN

Release Date: December 2023

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