
U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
UnitedHealth Group
Kansas
Department of Health and Environment
ahca
American Health Care Association
Trust for America's Health
WWW.HEALTHYAMERICANS.ORG
CSTE
Council of State and Territorial Epidemiologists
APHN
NORTH DAKOTA
DEPARTMENT of HEALTH
THE UNIVERSITY OF UTAH
NH RECOVERY
health and human services
DHCS
California Department of
HealthCareServices
astho
AAFP
AHRQ
Georgetown University
school of medicine
AMA
AMERICAN MEDICAL ASSOCIATION
NCQA
Measuring quality. Improving health care.
NACCHO
National Association of County & City Health Officials
The LEWIN GROUP
MAYO CLINIC
de Beaumont Foundation
Center for Medicare & Medicaid
INNOVATION
INSTITUTE OF MEDICINE
VCU
AHIP
America's Health Insurance Plans
ACPM
American College of Preventive Medicine
ACP
AMERICAN COLLEGE OF PHYSICIANS
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
WPHCA
Wisconsin Primary Health Care Association
ODH
Colorado Department of Public Health and Environment
DukeMedicine
NATIONAL ACADEMY for STATE HEALTH POLICY
CDC
RTI INTERNATIONAL
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
American Board of Family Medicine
NAMD
National Association of Medicaid Directors
KAISER PERMANENTE

astho™

Institute of Medicine Roundtable

Population Health Improvement and the ASTHO-Supported PC-PH Collaborative

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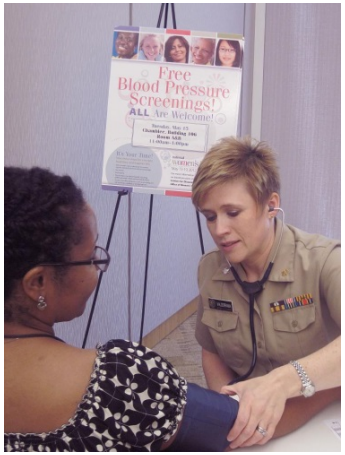
ASTHO Million Hearts State Learning Collaborative

Project Goals:

- Improve hypertension control and to achieve the national Million Hearts goal.
- Identify and build networks and cross-sector partnerships to control hypertension.
- Test models for collaboration between public health and health care.
- Experience a QI process to affect practice and policy at all levels of the system.
- Focus on systems, sustainability and spread.

Focus on NQF 18:

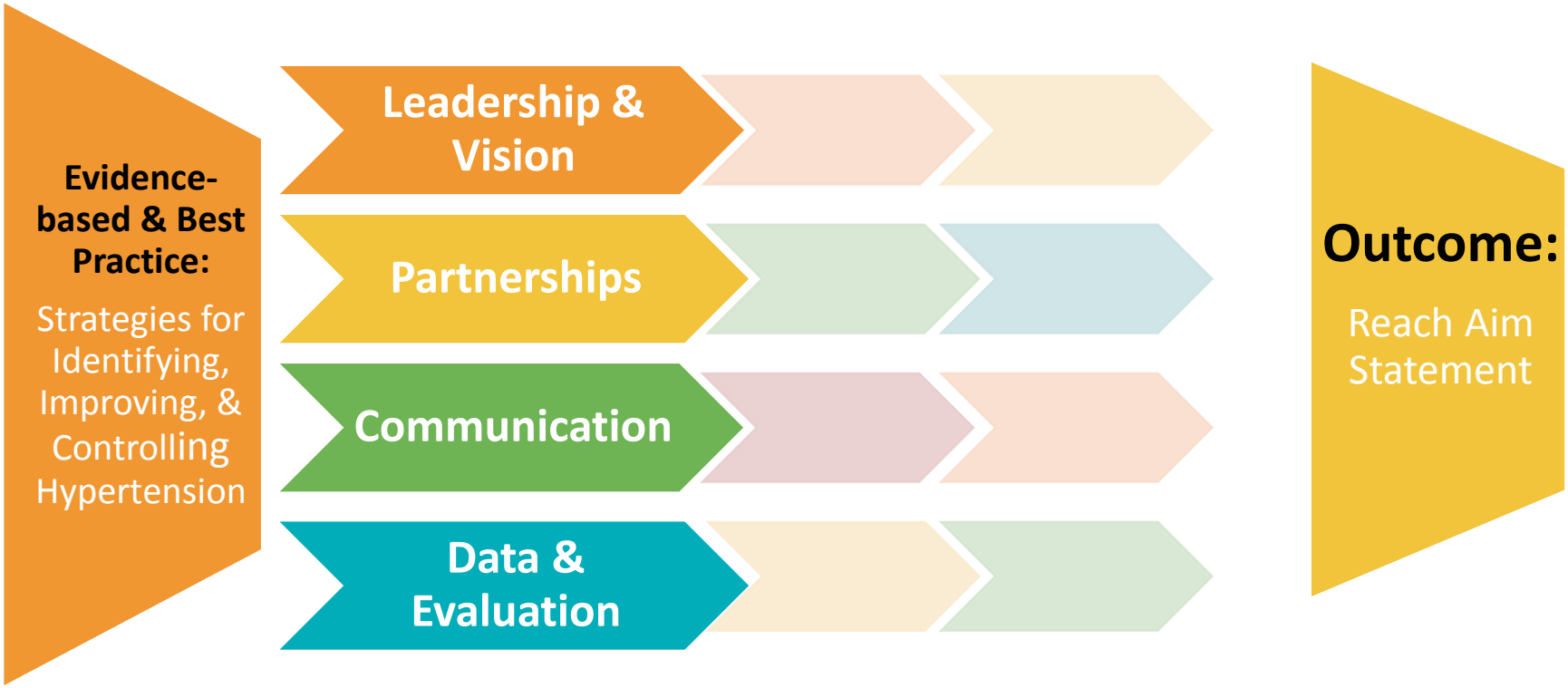
- The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year



Five Key Levers for QI Driven Impact

- ✓National, State, Local Leadership
- ✓Community and Clinical Resources and Linkages
- ✓Data-Driven Action
- ✓Standardized Protocols
- ✓Financing and Policy Approaches

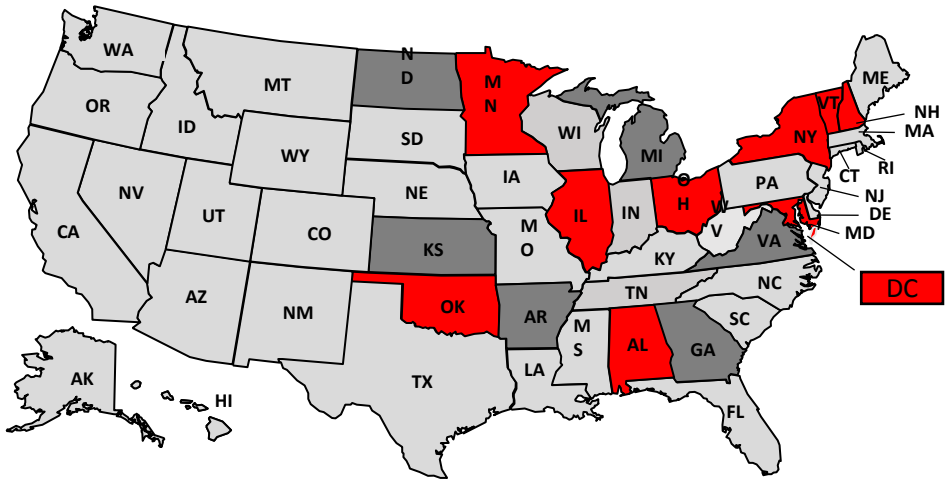
Multi Partner Assessment



State Systems Change Leading to Real Change

In Year One with 10 States:

- Over 250 PDSA Pilot Cycles
- 4 Multi-State Meetings
- 69 Peer Group Virtual Convenings
- Over 150 multiple partners and stakeholders (payers, hospital systems, QIOs, FQHC's, local public health, community partners, state public health, health informatics, paramedic and other non-traditional partners) working together



KEY
Red = Continuing states
Dark grey = New states

State Impact: Number of People Reached
Current: 89,187
Potential: 1,567,447

Outcomes: Examples

- In 9 months, several clinics demonstrated improvement in the percentage of hypertensive patients under control by as much as **12 percentage points**.
  - A NH clinic improved control rates in its hypertension registry from 64% to 73% in 7 months
- All 10 states report that this project has influenced other CDC-funded chronic disease work
- Six states report that this work has informed their SIM applications

Outcomes

Standardizing Protocols:

- **DC** clinics diagnosed 3,950 new patients, including 1,648 from their target population (Ward 5 & 7).
- **NY** reduced their undiagnosed patients from 7% to 4.7% among reporting FQHCs and hypertension prevalence increased an average of 4.8% (range 1.7% to 14.2%).
- **OH** had an increase of hypertension control rates increase from 69.7% to 73.4% from reporting clinics.

Data:

- **OH** has enrolled 7,300+ patients into their registry in 3 months.
- **DC** has over 1,000 patients in their current registry and are developing 2 new registries.
- One **IL** clinic has 3,000+ patients in their dashboard.
- All FQHCs in **NH** began reporting on NQF18 to the NH Dep't. of Health and Human Services
- Participating clinics in **MN** can all pull NQF18 data from their EHR systems and report to MDH.

Innovative Approaches in the Learning Collaborative

- Lending blood pressure monitors from local libraries **(VT)**
- Funding registry managers in clinics using Community Health Needs Assessment benefits **(NH)**
- Using screening and referral protocols in faith-based communities and barbershops **(AL, DC, IL)**
- Using screening and referral protocols in fire departments **(MD, OH)**
- Using screening and referral protocol on military bases and healthcare systems **(AL)**
- Partnering with the Choctaw Nation Health System (**OK)**

Addressing Barriers to Sustaining and Spreading Successful Models of Population Health Improvement

- ✓ *Implementing a Quality Improvement Approach*
- ✓ *Linking Community Resources*
- ✓ *Using Data to Drive Action*
- ✓ *Building a Health Workforce Skilled in Health System Transformation*
- ✓ *Identifying Resources to Sustain and Spread Models of Success*