WELCOME TO THE 2022 CARDIOVASCULAR COLLABORATIVE MID-YEAR MEETING

Chrissy Meyer, MBA
Communications Director
American Heart Association
TODAY’S AGENDA

• Announcements

• The Role of Pharmacists in Cardiovascular Disease Prevention and Management

• Update on 2022–2026 Strategic Plan

• Closing
Housekeeping: Mute/Unmute

Please mute your audio
Cameras off
Questions at any time in chat box
Meeting will be recorded
Participation encouraged :)
NATIONAL WEAR RED DAY RECAP
SUBMIT A SUCCESS STORY!

We want to hear about what other Collaborative members are working on, share accomplishments, and share lessons learned with one another. We would love to hear from you, whether it is a success big or small. We will be featuring a new success story in each newsletter, so be sure to submit one to be featured!

For more information or to submit a success story, please email Rachel Sehr.
The Role of Pharmacists in Cardiovascular Disease Prevention and Management
THE ROLE OF PHARMACISTS IN CARDIOVASCULAR DISEASE PREVENTION AND MANAGEMENT

Dr. Sharrel Pinto
Department Head | Allied and Population Health
Hoch Endowed Professor for Community Pharmacy Practice
Director | Community Practice Innovation Center (CPIC)
Email: sharrel.pinto@sdstate.edu

Dr. Deidra VanGilder
Associate Professor | Pharmacy Practice
Ambulatory Care Pharmacist at the Brown Clinic
Core Faculty | Community Practice Innovation Center (CPIC)
Email: deidra.vangilder@sdstate.edu
LEARNING OBJECTIVES

- Describe methods to identify care gaps within their communities.
- Identify different stakeholders impacting patient care and their specific interests.
- Discuss strategies for working with pharmacy partners.
1. WHICH OF THE FOLLOWING ARE KEY HEALTH CARE PARTNERS IN YOUR COMMUNITY? CHECK ALL THAT APPLY.
2. WHAT SERVICES ARE PROVIDED BY PHARMACISTS IN OUR STATE? CHECK ALL THAT APPLY.
3. WHAT CHALLENGES DO YOU FACE IN YOUR CURRENT ROLES THAT A PHARMACISTS COULD ALLEVIATE? CHECK ALL THAT APPLY.
Your doctor wants you to take 5 new pills and lose 50 lbs. okay bye!

Um what?
DRUGS DON’T WORK IN PATIENTS WHO DON’T TAKE THEM!

-C. EVERETT KOPP
## IDENTIFYING CARE GAPS

<table>
<thead>
<tr>
<th><strong>Review</strong></th>
<th>Review your landscape</th>
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<tbody>
<tr>
<td><strong>Think</strong></td>
<td>Think outside the box, but don't forget currently established pathways and collaborations</td>
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<tr>
<td><strong>Center</strong></td>
<td>Center the process around the patient</td>
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</table>
| **Intertwine** | Intertwine your investigative process with the 3 Ps  
• Patients, Practitioners, Payers |
| **State**  | State Departments of Health are often an under-utilized resource for forging pharmacy partnerships |
IDENTIFYING CARE GAPS

CDC 1815: THE PLAN

1. Increase engagement of pharmacists in the provision of medication management.
2. Promote the adoption of MTM between pharmacists and physicians.
PROJECT OVERVIEW

PROJECT TIMELINE

YEAR 1
- Landscape Analysis with Stakeholders
  2018-2019

YEAR 2
- Develop, Educate, & Engage Stakeholders
  2019-2020

YEAR 3
- Implement, Market, & Enroll
  2020-2021

YEAR 4

YEAR 5
- Evaluate Sustainabilty & Payment Models
  2022-2023

SOUTH DAKOTA COMMUNITY-BASED PRACTICE MODEL FOR DIABETES & CARDIOVASCULAR DISEASE (CVD)
LANDSCAPE ANALYSIS STRATEGY

Three Stakeholder Groups

Patients
Practitioners
Payers

Elicitation Interview (90 minutes)
Focus Group (3 hours)

Data Collection

Goal
To assess *needs* and community *assets*. 

South Dakota State University
Examples of “Other” Organizations
1. Federally Qualified Health Care Centers (FQHCS)
2. South Dakota Urban Indian Health
3. State Medicaid and Home Health Care
4. Regional Pharmacy Chains: e.g. Lewis Drug
5. Independent Pharmacies
GAPS - NEEDS - PARTNER ENGAGEMENT- STRATEGIES
PATIENT GROUP: HEALTHCARE JOURNEY

Coping
- Warning Signs & Symptoms
- Care Seeking
- Diagnosis
- Treatment Plan
- Initiate Treatment
- Medication & Treatment Adherence
- Behavior & Lifestyle Mod.
- Recovery/Maintenance/Stabilized

Screening
PATIENT GROUP: HEALTHCARE JOURNEY

Screening

Warning Signs & Symptoms → Care Seeking → Diagnosis → Treatment Plan → Initiate Treatment → Medication & Treatment Adherence → Behavior & Lifestyle Mod. → Recovery/Maintenance/Stabilized

Coping
I haven’t told my family that I have this disease…going on 7 years now. It’s too shameful and I’m embarrassed. We haven’t been able to see our doctors for months. I know I’ve had this for a while but it would be good to check in with someone.

The doctor tells you to do something, well if it costs me any money I’m not really interested.

We were doing great when we joined the Better Choices Better Health Program. When that stopped, we went back to bad habits.

I wish I had talked more with my doctor about what I was feeling. Thankfully, I said something to K (Pharmacist) and he told me to go in.

I haven’t told my family that I have this disease…going on 7 years now. It’s too shameful and I’m embarrassed.

We haven’t been able to see our doctors for months. I know I’ve had this for a while but it would be good to check in with someone.
PRACTITIONER GROUP: CHALLENGES

- Understanding of MTM
- Using practitioners to schedule appointments
- Financial barriers for patients
- Lack of facility space
- Staff turnover
- Lack of time
- Patients don't see value in diabetes education
- Patient transportation
- Proximity to other providers
- Attempt to improve provider referrals to MTM pharmacy services
“Um people have larger deductibles, not all of them understand that, um but it seems like they have larger deductibles and they’re just not willing to do out of pocket.”
- Certified Diabetes Educator

“I haven’t heard about MTM, but it would be amazing if they (my patients) could get this service. Gosh, I wish I could consult with the pharmacist for questions I get asked and have to look up ”
-RN, CDE
“Docs love it when we do the prior auths (authorizations) for them. It saves them time. Plus it opens up a conversation for other services like making recommendations or titrating doses.”

-Pharmacist

“Counseling space is always an issue in the pharmacy, but we just pick up the phone and call the patient or their family. We don’t let space stop us from helping our patients.”

-Pharmacist

“I don’t have a ton of time with my patients, which is a shame. I can’t tell you how often I’ve wanted a pharmacist on speed dial.”

-Provider

“We use our pharmacist all the on rounds. I wish I had the same access in clinic. It would cut down on so much of my time and stress.”

-APP
BUILDING GOALS AND STRATEGIES
PRACTITIONER GOALS AND STRATEGIES

- Improve Star Ratings
- Increase Ability to Meet Needs of Low Income Patients
One time I didn’t have money to get my blood pressure pills so I was waiting a week until I could get my check I went to [name of pharmacy] and the guy told me I should go to the hospital because my blood pressure was so high.

-Patient
Practitioner Goals for Practice in Next 5 Years

- Improve Star Ratings
- Increase Ability to Meet Needs of Low Income Patients
- Expand Programs and Create New Ones
- More Square Footage
- Increase Use of Diabetes Education Program
“I think it would be great in the beginning of any diagnosis. If you were told how to manage [diabetes] and to help you manage.”

-Patient
PRACTITIONER GOALS AND STRATEGIES

- Improve Star Ratings
- Increase Ability to Meet Needs of Low Income Patients
- Expand Programs and Create New Ones
- More Square Footage
- Increase Use of Diabetes Education Program
- Increase Medication Adherence & completion of MTM
Like, what does Metformin do? What does Glipizide do? Which one should I be cutting back on, you know, I don’t really know they act, you know what I mean? I could be much more educated on that.

-Patient
PRACTITIONER GOALS AND STRATEGIES

- Improve Star Ratings
- Increase Ability to Meet Needs of Low Income Patients
- Expand Programs and Create New Ones
- Have A1Cs less than 7
- Increase Medication Adherence and completion of MTM
- More Square Footage
- Increase Use of Diabetes Education Program
PRACTITIONER GOALS AND STRATEGIES

- Improve Star Ratings
- Increase Ability to Meet Needs of Low Income Patients
- Expand Programs and Create New Ones
- More Square Footage
- Increase Use of Diabetes Education Program
- Increase Medication Adherence & completion of MTM
- Have A1Cs less than 7
- Increase referrals to weight management

Practitioner Goals for Practice in Next 5 Years
PAYERS
PAYER GROUP

• Participants included representatives from three private health plans of large regional/international Integrated Delivery Networks

• Vast experience in the field, including high-level executives

• Various departments represented
  • Plan Structure and Integrity
  • Provider Contracting and Engagement
  • Population Health Services
  • Care Coordination

• None of the payers interviewed, at the time, reimbursed for pharmacist-based services

“I’m not sure that the health system or even the health plan fully understands it in full transparency right now.”

“…if I’m sending them a five-page report and there’s really just one element of information…buried on the third page…chances are they’re not going to get the information they need.”

“Traditionally, this has been the role of only the physician. This isn’t working. Pharmacists could take the burden off providers, allowing them more time to provide valuable patient visits.”
Traditionally, this has been the role of only the physician. This isn’t working. Pharmacists could take the burden off of providers, allowing them more time to provide valuable patient visits.
PAYER/OTHERS GROUP: CHALLENGES

- Education
- Communication
- Holistic Wellness
**Relationship-building Years 1 & 2**

- Connect with regional health plan leaders to understand their process, concerns, and goals for reimbursing pharmacy-based services

**Engagement Years 1 & 2**

- Invite health plan representatives to participate in project programs and activities
- Discuss mutual goals and plans between organizations through regular, consistent follow-up meetings

**Continued Collaboration Years 2 - 5**

- Share findings from ongoing projects
- Provide resources to aid in the development of policies for pharmacy-based reimbursement
- Tailor forms, policies, and trainings to best assist regional health plans

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**PAYER GOALS AND STRATEGIES**
WHAT’S IN IT FOR YOU?
EMPOWERING PATIENTS

ENHANCING PRACTITIONER/EMPLOYEE WELL-BEING

ENGAGING PAYERS
DECREASED STAFF TURNOVER
IMPROVED PATIENT HEALTH OUTCOMES
INCREASED JOB SATISFACTION
SERVICES PHARMACISTS CAN PROVIDE

- Community/Retail: MTM, Immunization, Medication Adherence, Prior Authorizations

- Ambulatory Care/Clinic Pharmacist: Disease State Management (DSM), Education, Medication Reconciliation, Transitions of Care (TCM), Chronic Care Management (CCM)

- Hospital Pharmacist: TCM, DSM, Education, Med Reconciliation, Discharge Counseling

- Long Term Care: DSM, Care coordination, Prior Authorization

- Other Opportunities
BEST PRACTICES WHEN WORKING WITH PHARMACIES/PHARMACISTS AND COMMUNITY PARTNERS

- Build on existing relationships and don’t hesitate to pick up the phone and call people
- Academia and State Organizations can be a resource
- Understand the structure of the organization and their priorities

- Align priorities with current or future work plans
- You may need to work from the ground up, start with a smaller department and build your network from within
- Build the bridge and breakdown silos
REFLECTION QUESTIONS

▪ What experiences have you had:
  • Working with SDSU
  • Engaging in collaborations with pharmacists
  • Developing programs across your communities
  • If you were to begin, what would be your biggest challenge and how would you plan to overcome it

SESSION OBJECTIVES

1. Describe methods to identify care gaps within their communities.
2. Identify different stakeholders impacting patient care and their specific interests.
3. Discuss strategies for working with pharmacy partners.
Update on the 2022-2026 Strategic Plan

PRESENTED BY:
SARAH ANDERSON-FIORE OF EMOY CENTERS
Today’s Goals

- Share progress on Strategic Plan
- Give opportunity for feedback
- Discuss next steps
Strategic Planning Process

March - August: Gather data & perform interviews

September: Strategic Planning workshop

October - December: Refine Goals and Strategies

January - February: Refine Objectives

March - April: Finalize Plan
Approach to Strategic Planning

• Shared ownership of state plan
• High impact and evidence-based
• Realistic, achievable goals
• Consensus = 80% comfortable - “I can live with this”
A strategic plan includes:

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<th>Description</th>
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<td>A picture of the “preferred future”: A statement that describes how the</td>
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<td>“Aim for This”</td>
<td>future will look like if the organization achieves its ultimate aims.</td>
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<td><strong>Mission</strong></td>
<td>A statement of the overall purpose – describes what you do, for whom you</td>
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<td>“Talk About This”</td>
<td>do it, and the benefit.</td>
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<td><strong>Goals</strong></td>
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<td><strong>Objectives</strong></td>
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<td>“Measure These”</td>
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<td><strong>Activities</strong></td>
<td>Specific steps to be taken, by whom, to implement a strategy.</td>
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**South Dakota Cardiovascular Collaborative Strategic Plan, 2022-2026**

**VISION:** Healthy people, healthy communities, healthy South Dakota

**MISSION:** To improve quality of life for all through prevention and management of cardiovascular disease and associated risk factors

**PRIORITY POPULATIONS:** Native Americans, people living in rural areas, people with lower incomes

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<th>Goals Focus On</th>
<th>I. Advance health equity in prevention, treatment, and management of cardiovascular disease</th>
<th>II. Optimize health through prevention of chronic diseases</th>
<th>III. Improve response to acute cardiovascular incidents</th>
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| Strategies Work On | A. Collaborate with communities and priority populations to identify and address needs related to cardiovascular health | A. Promote increased physical activity across the lifespan | A. Strengthen the active EMS workforce | A. Support referral of adults with cardiovascular disease to management programs and resources |
|                    | B. Promote equitable access to prevention, treatment, and management programs and resources | B. Promote healthy food and beverage consumption | B. Promote adoption of the Cardiac Ready Community program | B. Promote utilization and support pharmacist-provided services, including medication therapy management |
|                    | C. Enhance partners’ organizational capacity to promote health equity across sectors | C. Promote commercial tobacco cessation | C. Promote continuity and collaboration of care at each point of the chain of survival | C. Support expansion of the CHW profession |
|                    |                                                                                      | D. Encourage annual preventive care visits and screenings | D. Bolster review and utilization of cardiovascular data | D. Maximize community-clinical linkages |
|                    |                                                                                      | E. Support healthcare professionals in counseling patients about risk factors and making referrals to prevention programs | E. Promote utilization of the latest cardiac and stroke guidelines |                                                                 |
|                    |                                                                                      | F. Support implementation of K-12 holistic health education programs |                                                                 |                                                                 |

**CORE PRINCIPLES**

- Emphasize health equity
- Engage partners and communities
- Collaborate across sectors and chronic disease programs
- Endorse holistic health promotion
- Use evidenced-based strategies
### Goal I: Advance health equity in prevention, treatment, and management of cardiovascular disease

#### STRATEGIES – what we’re working on

- **A.** Collaborate with communities and priority populations to identify and address needs related to cardiovascular health
- **B.** Promote equitable access to prevention, treatment, and management programs and resources
- **C.** Enhance partners’ organizational capacity to promote health equity across sectors

#### OBJECTIVES – what we’re measuring

1. Maintain or decrease the mortality rate from heart disease among Native Americans at 258.3 per 100,000.
2. Decrease the percentage of adults with an income of less than $25,000 who have ever been diagnosed with heart attack from 6.4% to 5%.
3. Increase the percentage of adults with an income of less than $25,000 who report having a health care provider from 74.8% to 77%.
4. Rural population objective is TBD.
5. Increase the percentage of patients who reported that their doctors “always” explained things in a way they could understand from 82% to 85%.
Goal I Clarifying Questions & Feedback

Use the **Chat Box to ask questions** about this Goal

Use the **Poll to share your overall impression** of the plan for this Goal
Goal II: Optimize health through prevention of chronic diseases

**OBJECTIVES – what we’re measuring**

1. Maintain or increase the percentage of adults classified as having a normal weight by BMI at 29.8%.
2. Increase the percentage of adults who meet physical activity guidelines of 150 minutes or more per week from 45.7% to 48%.
3. Decrease the percentage of adults who currently use tobacco from 26% to 23%.
4. Decrease the percentage of adults who have been told they have high blood pressure from 27.8% to 26%.
5. Increase the percentage of adults who report visiting their doctor for a routine checkup within the last year from 74.2% to 77%.

**STRATEGIES – what we’re working on**

A. Promote increased physical activity across the lifespan
B. Promote healthy food and beverage consumption
C. Promote commercial tobacco cessation
D. Encourage annual preventive care visits and screenings
E. Support healthcare professionals in counseling patients about risk factors and making referrals to prevention programs
F. Support implementation of K-12 holistic health education programs
Goal II Clarifying Questions & Feedback

Use the **Chat Box** to ask **questions** about this Goal

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**Goal III: Improve response to acute cardiovascular incidents**

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Goal III Clarifying Questions & Feedback

Use the **Chat Box** to ask **questions** about this Goal

Use the **Poll** to share your overall **impression** of the plan for this Goal
## Goal IV: Support cardiovascular disease management

### OBJECTIVES – what we’re measuring

1. Increase the number of participants who complete Better Choices, Better Health SD from 460 to 560
2. Increase the percentage of adults with **high blood pressure** who regularly check their blood pressure from 63% to 65%.
3. Maintain or decrease the percentage of adults who have ever been diagnosed with a heart attack at 3.5%.
4. Maintain or decrease the percentage of adults who have ever been diagnosed with stroke at 2.2%.

### STRATEGIES – what we’re working on

A. Support referral of adults with cardiovascular disease to management programs and resources
B. Promote utilization and provide support of pharmacist-provided services, including medication therapy management
C. Support expansion of the CHW profession
D. Maximize community-clinical linkages
Goal IV Clarifying Questions & Feedback

Use the **Chat Box to ask questions** about this Goal

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Where do we fit in?
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### III. Improve response to acute cardiovascular incidents

A. Strengthen the active EMS workforce  
B. Promote adoption of the Cardiac Ready Community program  
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D. Bolster review and utilization of cardiovascular data  
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### IV. Support cardiovascular disease management

A. Support referral of adults with cardiovascular disease to management programs and resources  
B. Promote utilization and provide support of pharmacist-provided services, including medication therapy management  
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<td>1. Increase the number of participants who complete Better Choices, Better Health SD from 460 to 560</td>
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<tr>
<td>2. Increase the percentage of adults with high blood pressure who regularly check their blood pressure from 63% to 65%</td>
</tr>
<tr>
<td>3. Maintain or decrease the percentage of adults who have ever been diagnosed with a heart attack at 3.5%</td>
</tr>
<tr>
<td>4. Maintain or decrease the percentage of adults who have ever been diagnosed with stroke at 2.2%</td>
</tr>
</tbody>
</table>

**Strategies Focus On**

<p>| A. Collaborate with communities and priority populations to identify and address needs related to cardiovascular health |
| B. Promote equitable access to prevention, treatment, and management programs and resources |</p>
<table>
<thead>
<tr>
<th>C. Enhance partners’ organizational capacity to promote health equity across sectors</th>
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<tbody>
<tr>
<td>A. Promote increased physical activity across the lifespan</td>
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<tr>
<td>B. Promote healthy food and beverage consumption</td>
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<td>C. Promote commercial tobacco cessation</td>
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<td>D. Encourage annual preventive care visits and screenings</td>
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<td>E. Support healthcare professionals in counseling patients about risk factors and making referrals to prevention programs</td>
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<tr>
<td>F. Support implementation of K-12 holistic health education programs</td>
</tr>
</tbody>
</table>

**CORE PRINCIPLES**

Emphasize health equity | Engage partners and communities | Collaborate across sectors and chronic disease programs | Endorse holistic health promotion | Use evidenced-based strategies | Support referral of adults with cardiovascular disease to management programs and resources | Promote utilization and support pharmacist-provided services, including medication therapy management | Support expansion of the CHW profession | Maximize community-clinical linkages
Thank you
2017-2021 Strategic Plan Progress Report

This five-year progress report was recently released and highlights the formation and function of the Collaborative, examines the progress made on the previous strategic plan, reviews key goal area accomplishments, and describes a few lessons learned over this period and the ways the Collaborative is looking ahead.

2022 Cardiovascular Collaborative Kickoff Meeting

Tuesday, May 3rd and Wednesday, May 4th
Please fill out the evaluation survey!

THANK YOU FOR JOINING US TODAY!