



MARYLAND MILLION HEARTS PARTNER PROFILES



MARYLAND
Department of Health
and Mental Hygiene



MARYLAND MILLION HEARTS

PARTNER PROFILES

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Partner Profile

Department of Health and Mental Hygiene STATE HEALTH DEPARTMENT

GOAL: By June 30, 2016, The Maryland Department of Health and Mental Hygiene Center for Chronic Disease Prevention and Control will improve clinical and community linkages through the use of community health workers and community referrals in order to decrease emergency department visits for high blood pressure by 5% below baseline and improve blood pressure control by 5% above baseline.

MAIN INITIATIVE: Expand access to quality care and promote wellness and healthy lifestyles through a holistic approach to increase awareness and manage chronic conditions such as hypertension, diabetes, and prediabetes.

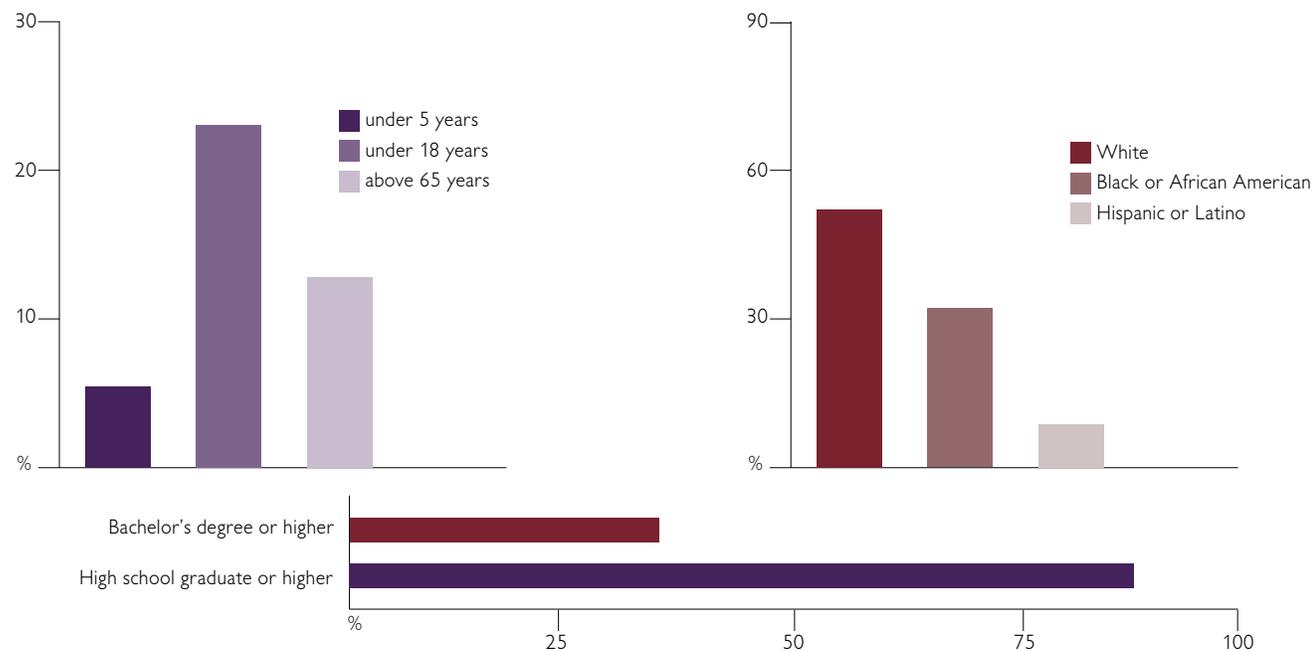
STATE HEALTH STATISTICS¹

+ ED visit rate due to hypertension: 246 per 100K population

+ ED visit rate due to diabetes: 192 per 100K population

STATE DEMOGRAPHICS²

POPULATION 5,976,407 | MEDIAN HOUSEHOLD INCOME \$73,538 | PERSONS BELOW POVERTY LEVEL 9.8%



ACTIONS

✓ Team-Based Care

Increase engagement of non-physician team members (i.e., nurses, pharmacists, and patient navigators) in hypertension and diabetes management in health care systems.

✓ Education/Training

Raise awareness, educate, and engage patients, providers, and other stakeholders.

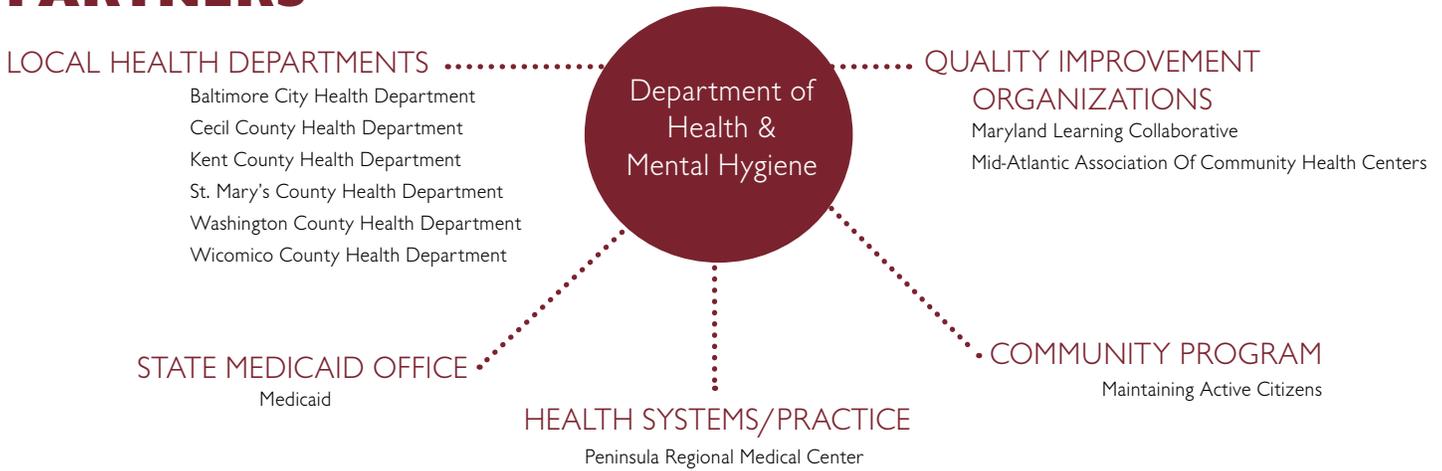
✓ Standardizing Practice

Increase the institutionalization and monitoring of standardized practices at the provider and systems levels.

✓ Data Aggregation

Increase the institutionalization and monitoring of aggregated quality measures at the provider and systems levels.

PARTNERS



ACCOMPLISHMENTS

- 👑 Developing a data warehouse that will aggregate standardized data from all Federally Qualified Health Centers (FQHC) in Maryland.
- 👑 Extended the reach of Maryland Million Hearts by adding five new key partners in year two.
- 👑 Increasing partnerships across the state between private practices, FQHCs, health departments, and Managed Care Organizations.

LESSONS LEARNED

- 💡 Importance of building partnerships between public health and health systems to improve population health.
- 💡 Incorporation of overlapping strategies to address both hypertension and diabetes.
- 💡 Standardized activities across partners that were shown to have a positive impact on clinical outcomes.

¹<http://dhmh.maryland.gov/ship/SitePages/Home.aspx>
²<http://quickfacts.census.gov/qfd/states/24/24037.html>

Partner Profile

Baltimore City Health Department

LOCAL HEALTH DEPARTMENT

MAIN INITIATIVE: Increasing clinical-community linkages to care

TARGET INTERVENTION: Hypertension, Diabetes & Prediabetes

HEALTH STATISTICS¹

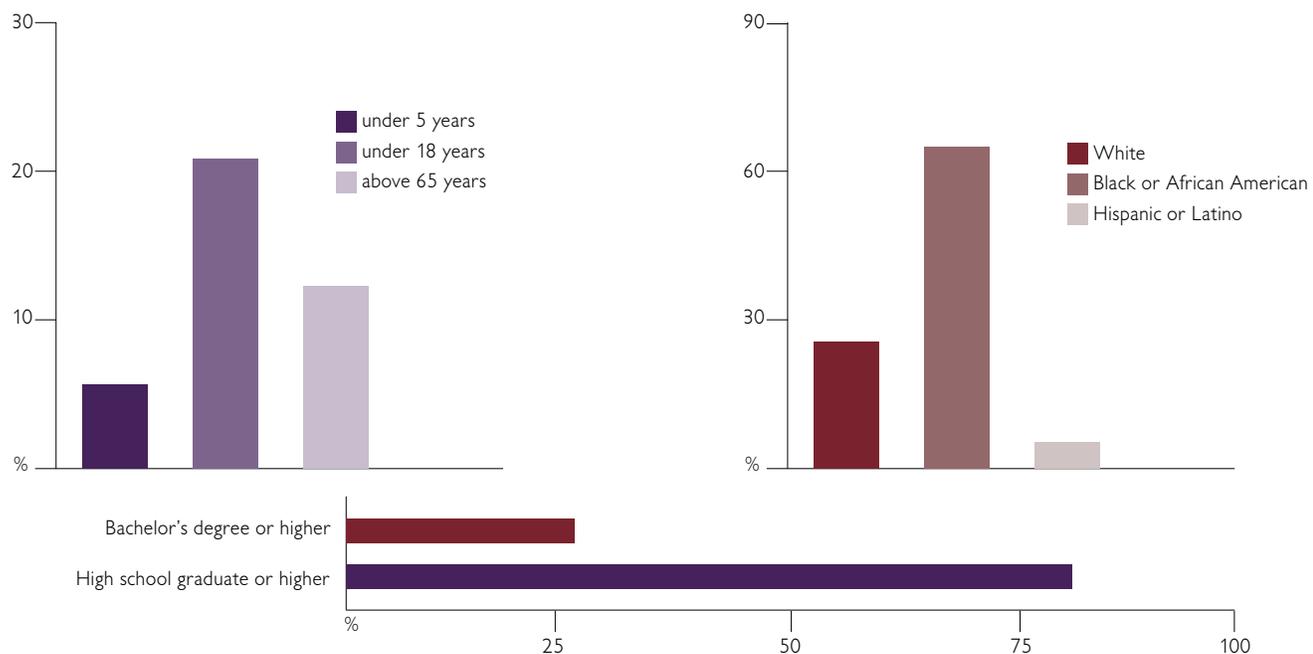
- + ED visit rate due to hypertension: 600 per 100K population (246 in Maryland)
- + ED visit rate due to diabetes: 502 per 100K population (192 in Maryland)

STRATEGIES

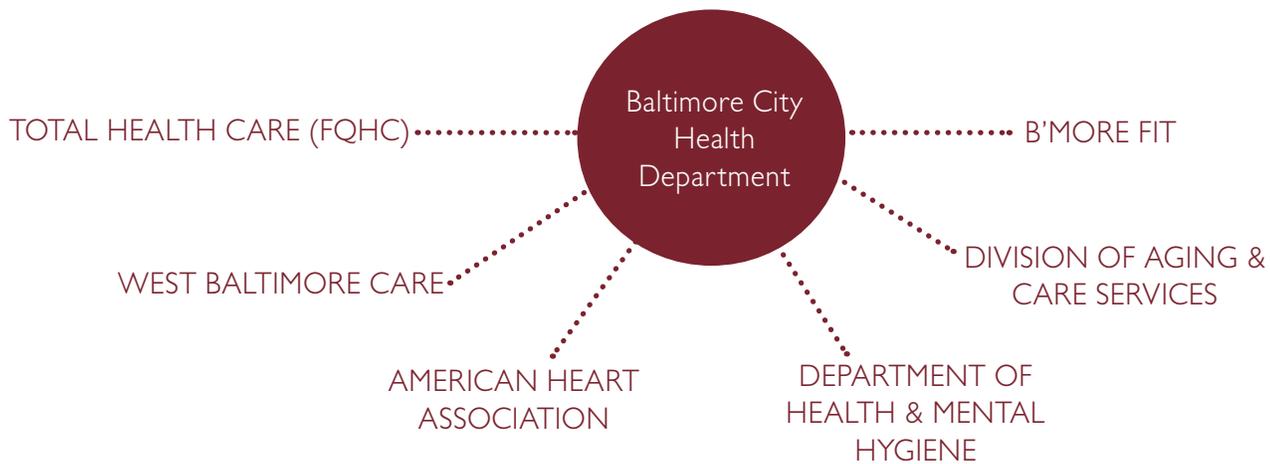
- Increase reporting, monitoring, and use of the following quality measures: NQF 18 (hypertension control) and NQF 59 (poor A1C control).
- Improve identification of undiagnosed persons with high blood pressure, prediabetes, and diabetes in clinical settings.
- Improve treatment and follow up of persons with high blood pressure or diabetes.
- Establish formal referral systems linking at-risk patients identified in the community to follow up health care.
- Increase prediabetes awareness.
- Engage non-physician team members in hypertension and diabetes management in health care system.
- Increase hypertension and diabetes awareness.
- Identify and promote community resources and programs for the prevention and control of high blood pressure, prediabetes, and diabetes.
- Promote self-measured blood pressure monitoring accompanied by clinical support.
- Implement policy or systems in health care settings that encourage a multi-disciplinary approach.

CITY DEMOGRAPHICS²

POPULATION 622,793 | MEDIAN HOUSEHOLD INCOME \$41,385 | PERSONS BELOW POVERTY LEVEL 23.8%



PARTNERS



ACTIONS

- ✓ Created and distributed localized hypertension and diabetes community resource inventories to increase community access to care.
- ✓ Used Resource Access Cards (RAC) system to track blood pressure of B'more Fit participants.
- ✓ Utilized FQHC to identify high risk patients.
- ✓ Provided participants with hypertension home blood pressure cuffs and training to monitor blood pressure at home.
- ✓ Provided administrative and program support to Total Health Care staff.
- ✓ Enrolled 22 patients with hypertension and 28 with diabetes in eight week monitoring program.
- ✓ Distributed info on smoking cessation, exercise, and healthy eating classes to community members.
- ✓ Tracked patients using Community Health Workers to facilitate follow up and referrals.
- ✓ Formed chronic disease self-management classes along with the Division of Aging and Care Services.

ACCOMPLISHMENTS

- 👑 Targeting high risk patients in zip codes most affected by hypertension and diabetes
- 👑 Identified 19 participants with A1c above 9.0%. (Q4)
- 👑 Identified 22 participants with diagnosed hypertension. (Q4)
- 👑 Identified 13 participants with controlled hypertension. (Q4)
- 👑 Average blood pressure of participants in Q4: 135/80.
- 👑 Trained 63 community-based staff/volunteers in proper blood pressure measurement.
- 👑 Worked with 50 high risk patients to provide eight weeks of team-based case management.
- 👑 Track blood pressure of 50 members of B'more Fit.
- 👑 Established referral systems and clinical-community linkages to care for high risk patients.
- 👑 Tracked self-reported health data of 22 individuals with hypertension and 28 individuals with diabetes.
- 👑 Identified 58 people with diabetes and 44 with HbA1c greater than 9% (Q3 2015).

LESSONS LEARNED

- 💡 Seek resources provided by American Heart Association
 - Explore possibility of implementing Heart360 platform
- 💡 Utilize tracking systems that allow for bi-directional data sharing and exact blood pressure measures
- 💡 Make sure initiatives are a good fit for partner organizations as well

¹<http://dhmh.maryland.gov/ship/SitePages/Home.aspx>

²<http://quickfacts.census.gov/qfd/states/24/24037.html>

Partner Profile

Cecil County Health Department

LOCAL HEALTH DEPARTMENT

MAIN INITIATIVE: Hypertension Best Practices Policies

TARGET INTERVENTION: Hypertension & Diabetes

HEALTH STATISTICS¹

+ ED visit rate due to hypertension: 235 per 100K population (246 in Maryland)

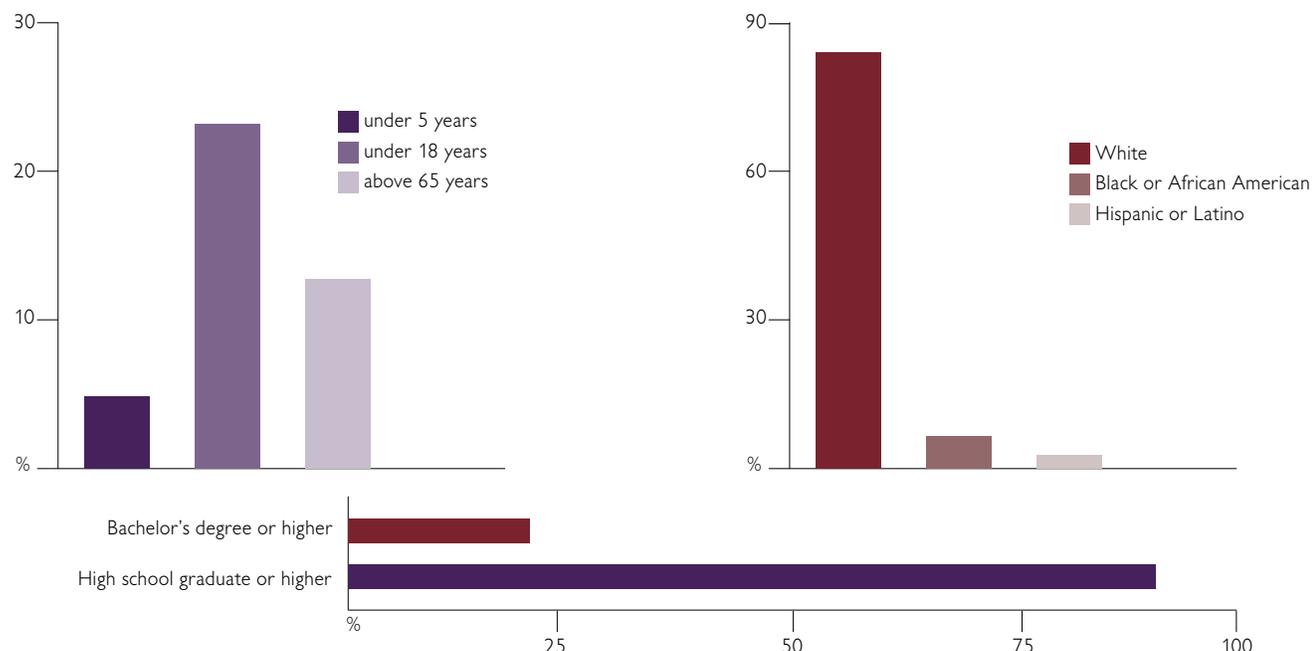
+ ED visit rate due to diabetes: 216 per 100K population (192 in Maryland)

STRATEGIES

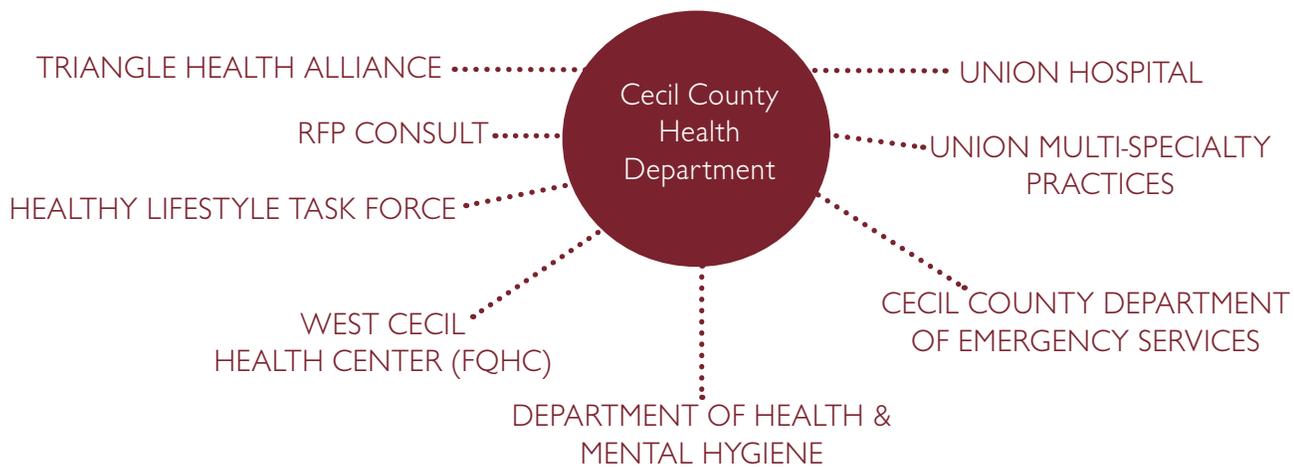
- Increase reporting, monitoring, and use of the following quality measures: NQF 18 (hypertension control) and NQF 59 (poor A1C control).
- Improve identification of undiagnosed persons with high blood pressure, prediabetes, and diabetes in clinical settings.
- Improve treatment and follow up of persons with high blood pressure or diabetes.
- Establish formal referral systems linking at-risk patients identified in the community to follow up health care.
- Engage non-physician team members in hypertension and diabetes management in health care system.
- Increase hypertension and diabetes awareness.
- Identify and promote community resources and programs for the prevention and control of high blood pressure, prediabetes, and diabetes.
- Implement policy or systems in health care settings that encourage a multi-disciplinary approach.
- Use Health Information Technology to facilitate bi-directional data sharing to support care coordination and to improve health outcomes.

COUNTY DEMOGRAPHICS²

POPULATION 102,383 | MEDIAN HOUSEHOLD INCOME \$66,689 | PERSONS BELOW POVERTY LEVEL 10.4%



PARTNERS



ACTIONS

- ✓ Developed two best practice policies with Union Hospital.
 - The Union Multispecialty Practice Hypertension Protocol to address best practices for the clinical management of hypertension.
 - The Hypertension Best Practice Policy for Adult Blood Pressure Screening Procedure to standardize adult blood pressure screening procedures.
- ✓ Developed patient handbook with Union Hospital for chronic disease self-management.
- ✓ Created community resource inventory available online via Union Hospital Webpage.
- ✓ Expanded use of Care2Care for hypertension, an IT platform used to capture patient care that occurs outside the clinical site.
- ✓ Designed educational posters on hypertension and diabetes with Healthy Lifestyle Task Force.
- ✓ Conducted an eight week case management program to track participant blood pressure in conjunction with the local West Cecil Health Center.
- ✓ Provided community health nurse to assist case management program.

ACCOMPLISHMENTS

- 👑 Enrolled eight community members in case management program.
- 👑 Trained six nurses on follow up and care coordination.
- 👑 Reached 924 community members through Community Volunteer Outreach Training program.
- 👑 Screened 48 people, identified 17 people with elevated blood pressure, and referred 17 people for follow-up care (Jan-June 2014).
- 👑 50% of participants in case management with controlled hypertension.
- 👑 Union Multi-Specialty Practices saw 5.4% increase in hypertension diagnoses and 1.17% increase in patients with controlled hypertension.
- 👑 West Cecil Health Center (Q4)
 - Identified 506 patients with diagnosis of hypertension.
 - Identified 362 patients with controlled hypertension.
 - 70% of participants in case management saw improvements in their blood pressure.
 - Monitored 12 people in case management program.
 - Identified two people in case management program with diabetes.
 - Identified one person in case management program with most recent A1c level greater than 9.0%.
 - Identified 12 people in case management program with hypertension.
- 👑 Union Multi-Specialty Practices (Q4)
 - Identified 6,296 patients with diagnosis of hypertension.
 - Identified 5,592 patients with controlled hypertension.

LESSONS LEARNED

- 💡 Engage the community through community task forces or screening events.
- 💡 Be able to work with the systems already in place at physicians' offices to ensure their participation in the initiative is effective.
- 💡 Recognize that partners must see a benefit to working collaboratively.
- 💡 Utilize already existing resources when developing policies, fliers, guidelines, or event ideas.
- 💡 Focus on patient centered care

¹<http://dhmh.maryland.gov/ship/SitePages/Home.aspx>

²<http://quickfacts.census.gov/qfd/states/24/24037.html>

Partner Profile

Kent County Health Department

LOCAL HEALTH DEPARTMENT

MAIN INITIATIVE: Check. Change. Control.¹

TARGET INTERVENTION: Hypertension & Diabetes

HEALTH STATISTICS²

+ ED visit rate due to hypertension: 247 per 100K population (246 in Maryland)

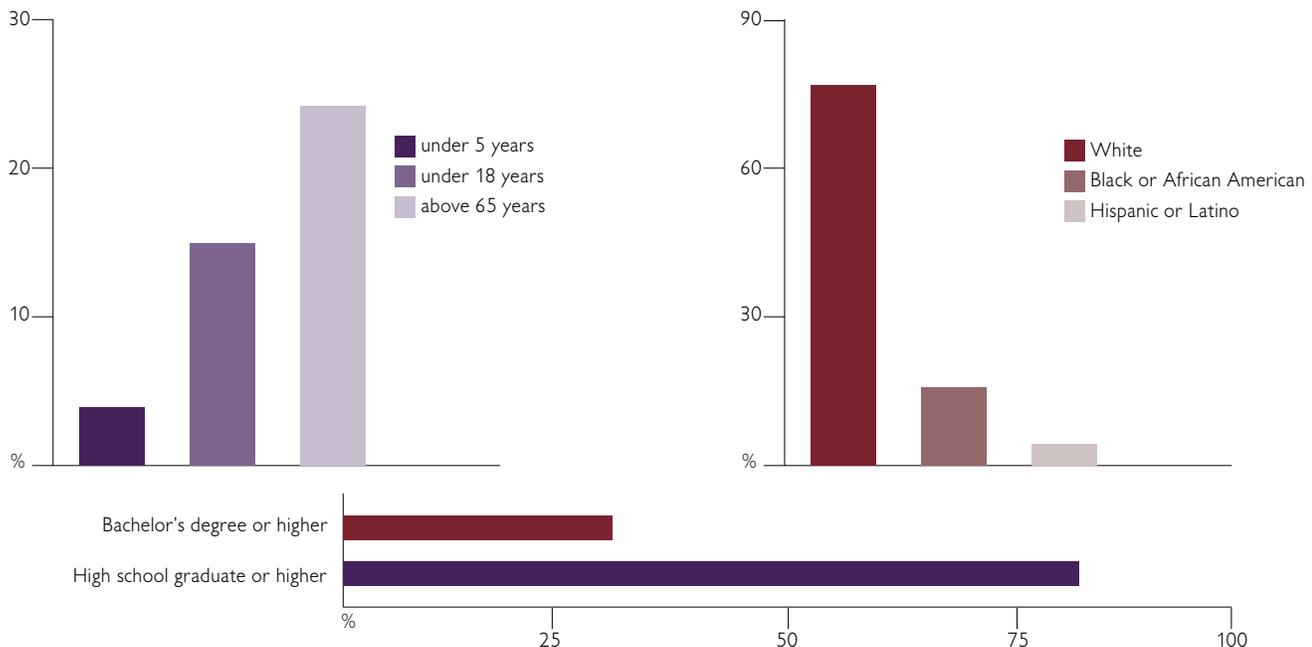
+ ED visit rate due to diabetes: 350 per 100K population (192 in Maryland)

STRATEGIES

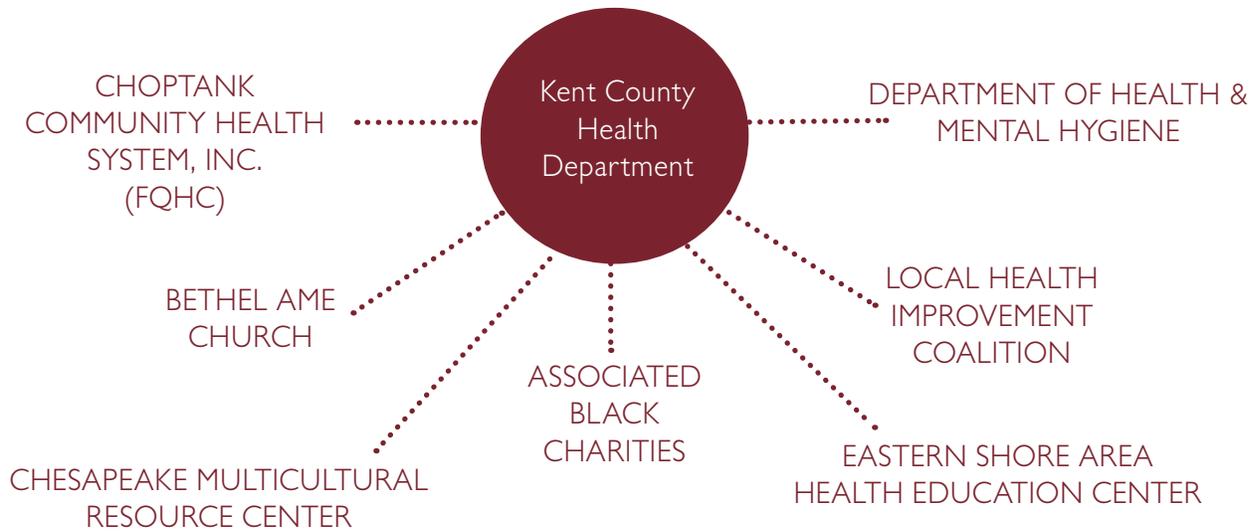
- Increase reporting, monitoring, and use of the following quality measures: NQF 18 (hypertension control) and NQF 59 (poor A1C control).
- Improve identification of undiagnosed persons with high blood pressure, prediabetes, and diabetes in clinical settings.
- Improve treatment and follow up of persons with high blood pressure or diabetes.
- Establish formal referral systems linking at-risk patients identified in the community to follow up health care.
- Engage non-physician team members in hypertension and diabetes management in health care system.
- Increase hypertension and diabetes awareness.
- Identify and promote community resources and programs for the prevention and control of high blood pressure, prediabetes, and diabetes.
- Promote self-measured blood pressure monitoring accompanied by clinical support.
- Implement policy or systems in health care settings that encourage a multi-disciplinary approach.
- Use Health Information Technology to facilitate bi-directional data sharing to support care coordination and to improve health outcomes.

COUNTY DEMOGRAPHICS³

POPULATION 19,820 | MEDIAN HOUSEHOLD INCOME \$56,259 | PERSONS BELOW POVERTY LEVEL 13.2%



PARTNERS



ACTIONS

- ✓ Expanded “Check. Change. Control.” efforts to include every mid-shore county.
 - Caroline, Dorchester, Kent, Queen Anne’s, and Talbot.
- ✓ Customized Heart360 platform to include parameters for provider alerts when tracking a participant’s blood pressure.
- ✓ Established bi-directional data sharing between participants, health providers, and health mentors.
- ✓ Identify participants through providers.
- ✓ Trained health mentors to assist and track participants’ home blood pressure monitoring.
- ✓ Established provider and mentor alert thresholds in Heart360 platform for blood pressure readings.
- ✓ Plan on tracking participants over four month period.
- ✓ Obtain a minimum of eight blood pressure readings.
- ✓ Created referral form for physicians to distribute.
- ✓ Created community blood pressure screening form.

ACCOMPLISHMENTS

- 👑 Introducing technology and increasing partner relationships to combat uncontrolled hypertension.
- 👑 Trained community health workers from 5 different counties.
- 👑 Identified 3,032 patients at Choptank Community Health System with hypertension.
- 👑 Identified 2,026 patients at Choptank Community Health System with controlled hypertension.

LESSONS LEARNED

- 💡 Conduct extensive research about any proposed initiatives, including a literature review.
- 💡 Look for similarities between the research and your target community.
- 💡 Reach out to other jurisdictions that have implemented similar initiatives.
- 💡 Look for existing materials and tools such as resources from the American Heart Association.
- 💡 Set a realistic timeline that will allow ample time for preparation.
- 💡 Explore assets of your partners and understand what they bring to the table.

¹Not fully implemented at time of interview

²<http://dhmh.maryland.gov/ship/SitePages/Home.aspx>

³<http://quickfacts.census.gov/qfd/states/24/24037.html>

Partner Profile

St. Mary's County Health Department

LOCAL HEALTH DEPARTMENT

MAIN INITIATIVE: Team-Based Care

TARGET INTERVENTION: Hypertension, Diabetes & Prediabetes

HEALTH STATISTICS¹

+ ED visit rate due to hypertension: 284 per 100K population (246 in Maryland)

+ ED visit rate due to diabetes: 214 per 100K population (192 in Maryland)

STRATEGIES

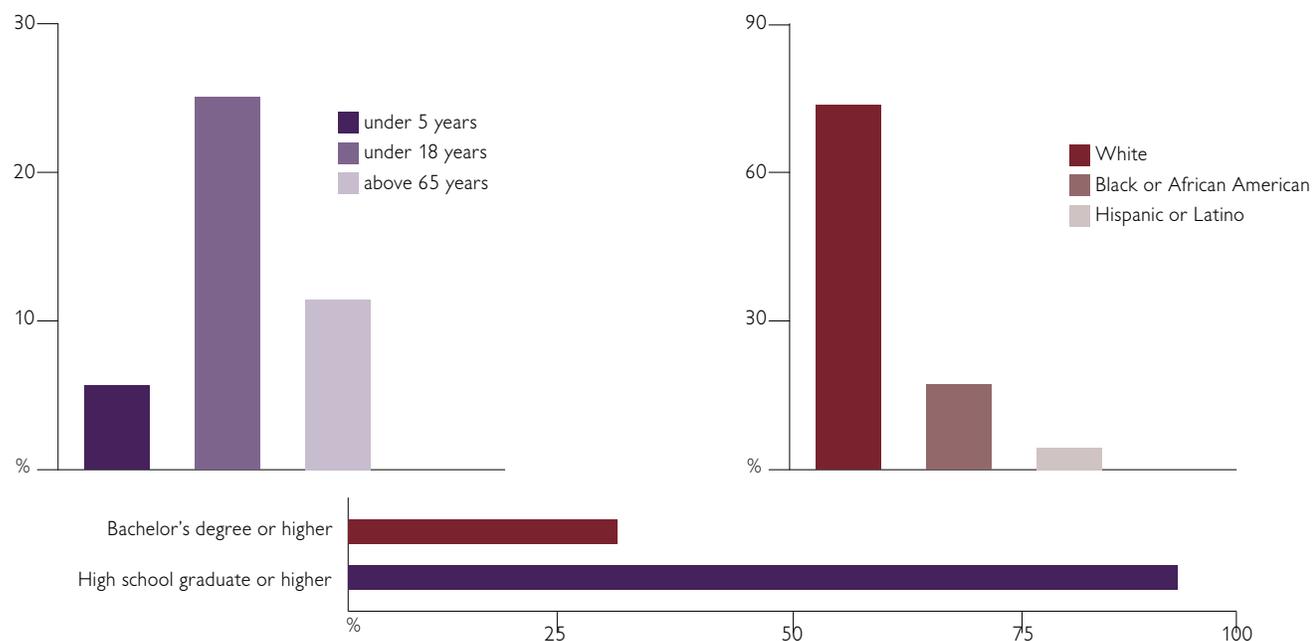
- Increase reporting, monitoring, and use of the following quality measures: NQF 18 (hypertension control) and NQF 59 (poor A1C control).
- Improve identification of undiagnosed persons with high blood pressure, prediabetes, and diabetes in clinical settings.
- Improve treatment and follow up of persons with high blood pressure or diabetes.
- Establish formal referral systems linking at-risk patients identified in the community to follow up health care.
- Engage non-physician team members in hypertension and diabetes management in health care system.
- Increase hypertension and diabetes awareness.
- Increase prediabetes awareness.
- Identify and promote community resources and programs for the prevention and control of high blood pressure, prediabetes, and diabetes.
- Implement policy or systems in health care settings that encourage a multi-disciplinary approach.
- Use Health Information Technology to facilitate bi-directional data sharing to support care coordination and to improve health outcomes.

COUNTY DEMOGRAPHICS²

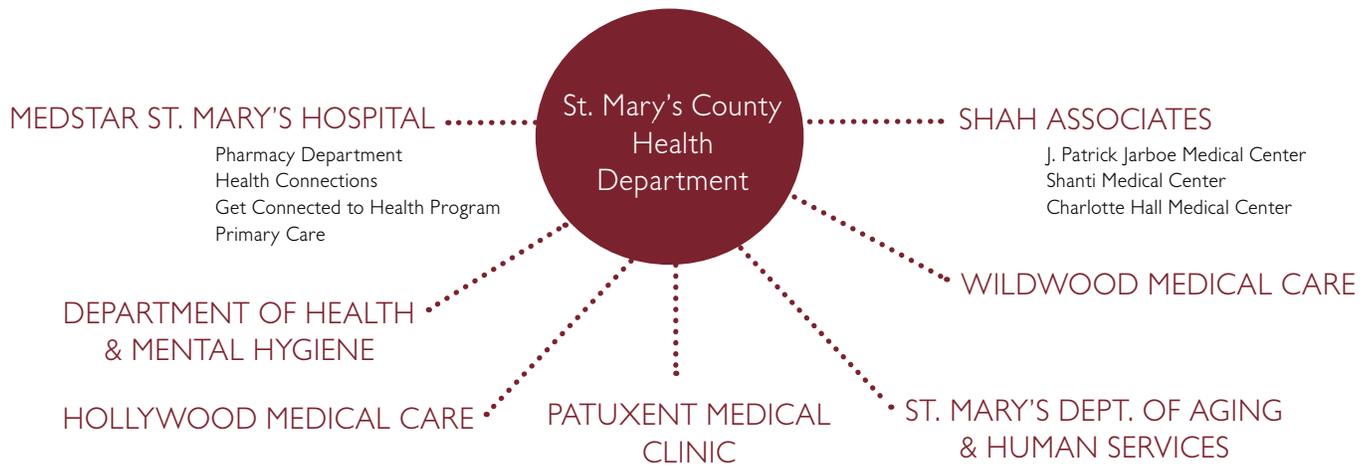
POPULATION 110,382

MEDIAN HOUSEHOLD INCOME \$85,672

PERSONS BELOW POVERTY LEVEL 7.2%



PARTNERS



ACTIONS

- ✓ Pharmacist was brought into team-based care management and required to work with the providers to assist with patient medication reconciliation.
- ✓ Created standardized data reporting template for community partners.
- ✓ Bi-directional data sharing between pharmacist and some practices was initiated.
- ✓ Created blood pressure card to help community members easily track their blood pressure
- ✓ Created blood pressure community guide detailing resources and information on hypertension.
- ✓ Adopted New Hampshire best practices policy for hypertension.
- ✓ Hired epidemiologist to assist in Million Hearts initiatives.
- ✓ Hosted mandatory monthly meetings with all partner groups to discuss Million Hearts initiatives.

ACCOMPLISHMENTS

- 👑 Identified 8,559 patients with hypertension.
- 👑 Identified 5,431 patients with controlled hypertension.
- 👑 Identified 4,046 patients with diabetes.
- 👑 Identified 297 whose most recent A1c level was greater than 9.0%.
- 👑 Identified 395 patients with prediabetes.
- 👑 Between January and April 2015, average rate for NQF 18 was 64.3% (above national average of 52%³).
- 👑 Referral system averages 37 patients per month to six different programs.
- 👑 Averaged over 1,000 patients identified with prediabetes per month during the first four months of 2015.
- 👑 Averaged 9.1% patients with HbA1c greater than 9% during the first four months of 2015.
- 👑 Six providers were incorporated into the initiative, out of eight in the region.
- 👑 Referred community members to six different programs (Smoking Cessation, Tobacco Quit Line, St. Mary's Alive!, Diabetes Prevention Program, Chronic Disease Self-Management Program, Nurse Care Coordinator).
- 👑 Made over 1,000 referrals to various educational and self-management programs.

LESSONS LEARNED

- 💡 Partner with people with clinical backgrounds that can communicate effectively with health providers.
- 💡 Collaborate with other counties and partners to address the varying needs of communities.
- 💡 Be willing to share program material and collaborate with prospective partners to help increase the reach of chronic disease management programs.
- 💡 Engage as many people as possible in the care team to ensure smooth transitions in the event the team experiences turnover.

¹<http://dhmh.maryland.gov/ship/SitePages/Home.aspx>

²<http://quickfacts.census.gov/qfd/states/24/24037.html>

³http://www.cdc.gov/dhdspl/data_statistics/fact_sheets/fs_bloodpressure.htm

Partner Profile

Washington County Health Department

LOCAL HEALTH DEPARTMENT

MAIN INITIATIVE: Parish Nursing Program

TARGET INTERVENTION: Hypertension & Diabetes

HEALTH STATISTICS¹

+ ED visit rate due to hypertension: 154 per 100K population (246 in Maryland)

+ ED visit rate due to diabetes: 182 per 100K population (192 in Maryland)

STRATEGIES

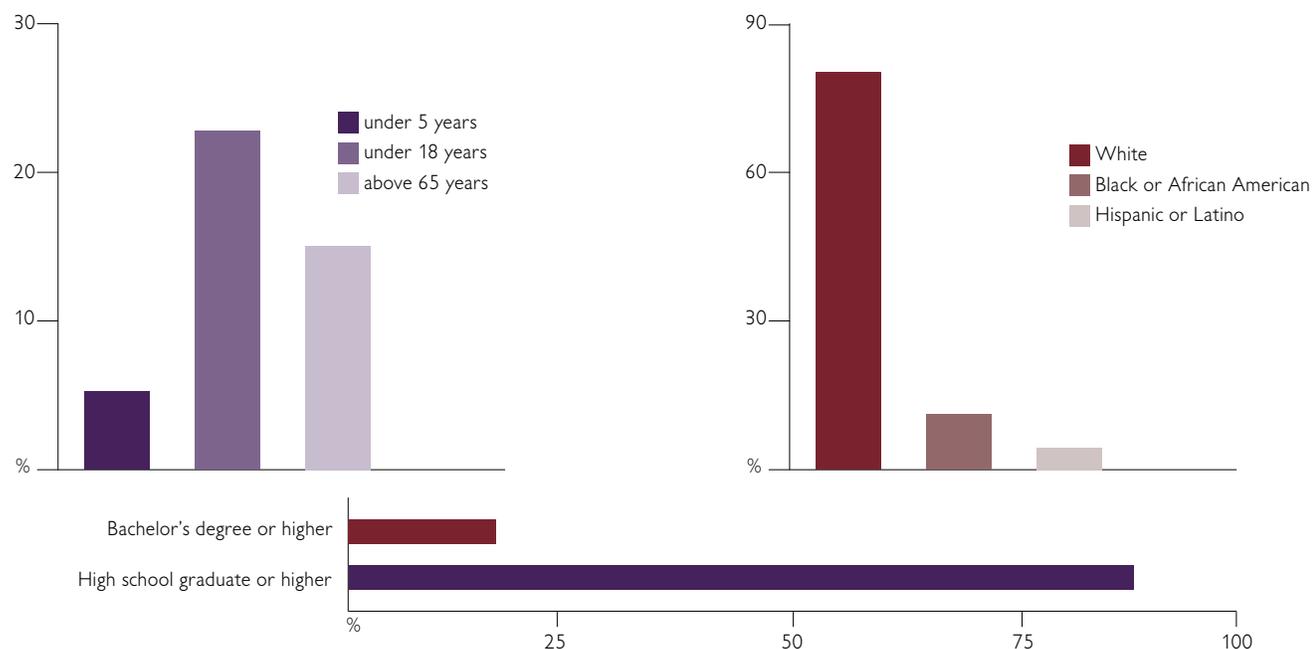
- Increase reporting, monitoring, and use of the following quality measures: NQF 18 (hypertension control) and NQF 59 (poor A1C control).
- Improve identification of undiagnosed persons with high blood pressure, prediabetes, and diabetes in clinical settings.
- Improve treatment and follow up of persons with high blood pressure or diabetes.
- Establish formal referral systems linking at-risk patients identified in the community to follow up health care.
- Engage non-physician team members in hypertension and diabetes management in health care system.
- Increase hypertension and diabetes awareness.
- Identify and promote community resources and programs for the prevention and control of high blood pressure, prediabetes, and diabetes.
- Promote self-measured blood pressure monitoring accompanied by clinical support.
- Implement policy or systems in health care settings that encourage a multi-disciplinary approach.

COUNTY DEMOGRAPHICS²

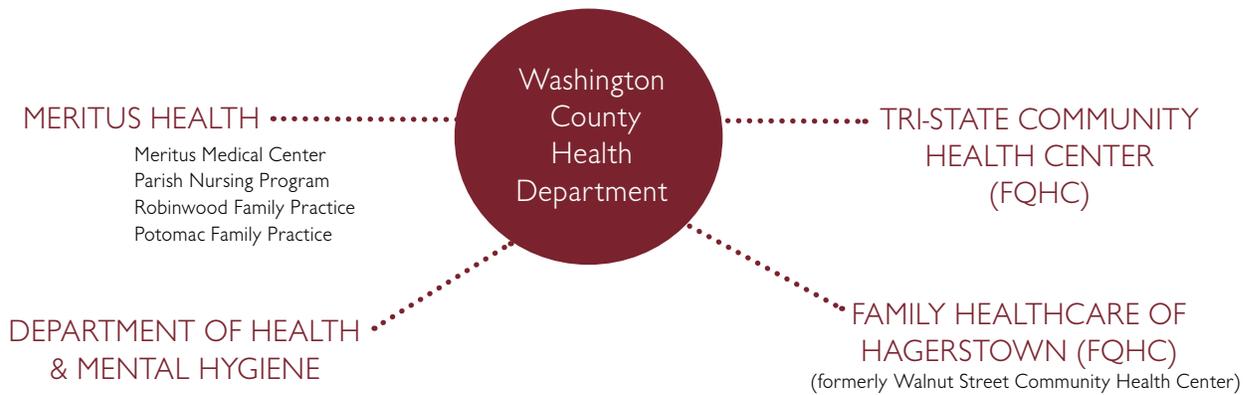
POPULATION 149,573

MEDIAN HOUSEHOLD INCOME \$55,609

PERSONS BELOW POVERTY LEVEL 12.4%



PARTNERS



ACTIONS

- ✓ Adopted New Hampshire blood pressure tracking card template for community members to easily track their blood pressure.
- ✓ Standardized blood pressure screening methods within Meritus Health System practices.
- ✓ Purchased and distributed blood pressure monitors to program participants for home monitoring.
- ✓ Held blood pressure screenings in the community.
- ✓ Hosted JNC 8 training sessions for medical practices.
- ✓ Conducted health risk assessment of Meritus employees.

ACCOMPLISHMENTS

- 👑 Screened 1,820 community members for hypertension in 2015.
- 👑 Referred 3,442 people to community programs or resources.
- 👑 Screened community members at two separate locations.
- 👑 Distributed info to 21,886 people in 2014.
- 👑 Screened 1,729 community members for hypertension in 2014.
- 👑 82% of the 51 participants in parish nursing program showed improvement in blood pressure in 2014.
- 👑 Registered over 1600 blood pressure screenings at local blood pressure kiosk.
- 👑 Identified 4,367 patients at Robinwood Family Practice with diagnosed hypertension.
- 👑 Parish Nursing Program to be featured in the Public Health Nurses Journal.
- 👑 Potomac Family Medicine
 - Identified 1,120 patients with diagnosed hypertension.
 - Average Q4 blood pressure of participants: 130/80.
 - 74% of participants saw improvements in blood pressure compared to baseline.
- 👑 Meritus Medical Center (Q3)
 - Screened 1387 members for hypertension.
 - Identified 46 members with elevated blood pressure readings.
- 👑 Identified 25 parish nurse volunteers, representing 15 faith communities in 2014.
- 👑 Identified 29 parish nurse volunteers, representing 18 faith communities in 2015.

LESSONS LEARNED

- 💡 Meet with partners early on and develop and discuss a plan together.
- 💡 One partner should not develop the initiative without ample input from the other community partners.
- 💡 Communicate clearly amongst community partners.
- 💡 Value the effectiveness of faith-based partnerships.

¹<http://dhmh.maryland.gov/ship/SitePages/Home.aspx>

²<http://quickfacts.census.gov/qfd/states/24/24037.html>

³http://www.cdc.gov/dhisp/data_statistics/fact_sheets/fs_bloodpressure.htm

Partner Profile

Wicomico County Health Department

LOCAL HEALTH DEPARTMENT

MAIN INITIATIVE: Chronic Disease Self-Management TARGET INTERVENTION: Hypertension, Diabetes & Prediabetes

HEALTH STATISTICS¹

+ ED visit rate due to hypertension: 393 per 100K population (246 in Maryland)

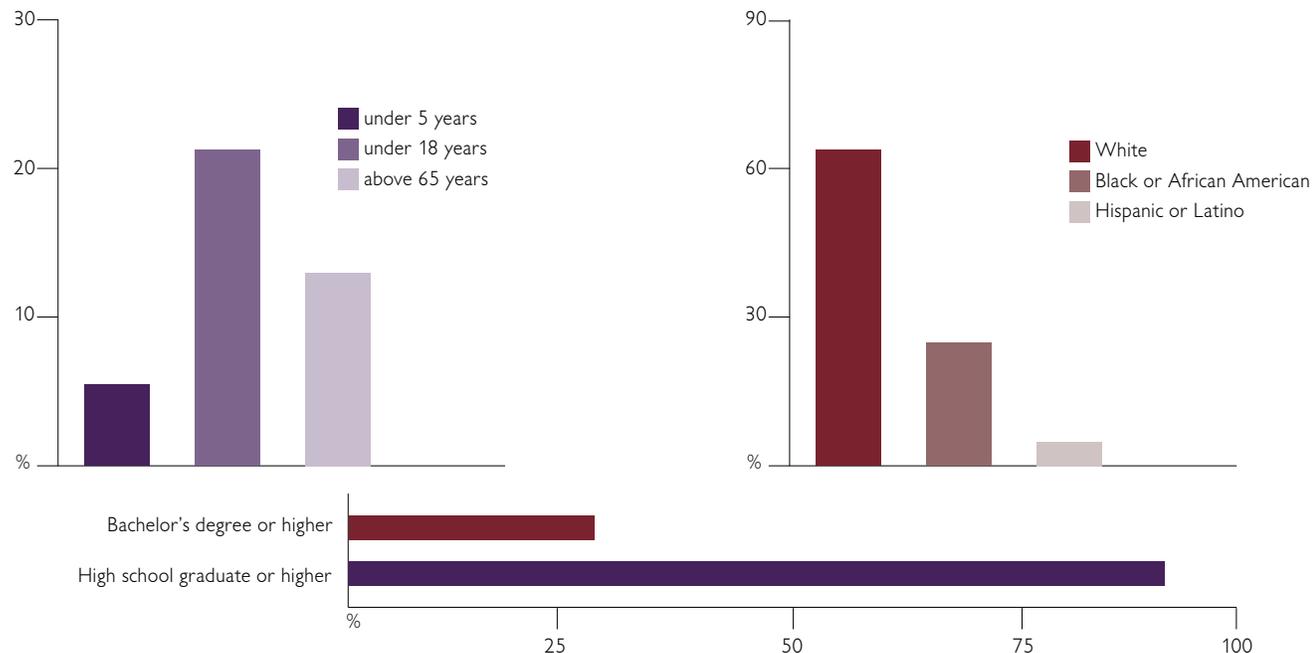
+ ED visit rate due to diabetes: 314 per 100K population (192 in Maryland)

STRATEGIES

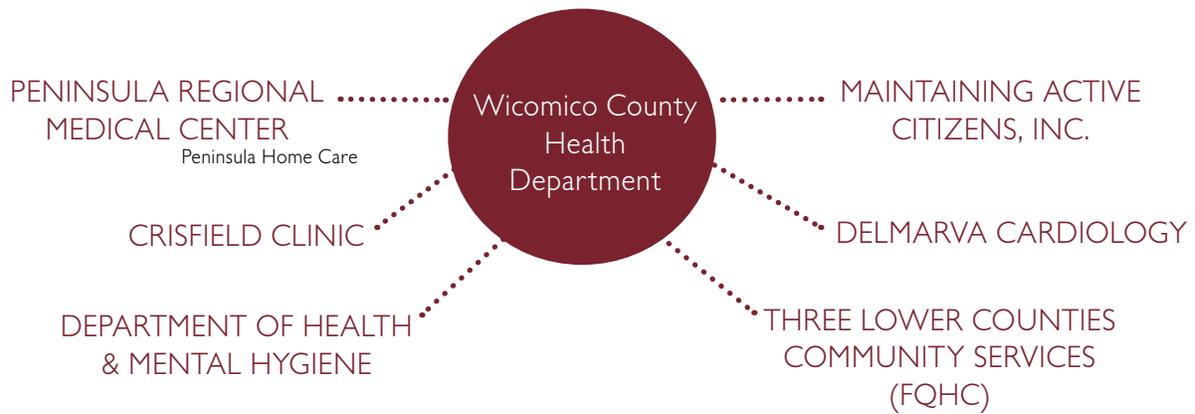
- Increase reporting, monitoring, and use of the following quality measures: NQF 18 (hypertension control) and NQF 59 (poor A1C control).
- Improve identification of undiagnosed persons with high blood pressure, prediabetes, and diabetes in clinical settings.
- Establish formal referral systems linking at-risk patients identified in the community to follow up health care.
- Engage non-physician team members in hypertension and diabetes management in health care system.
- Improve treatment and follow up of persons with high blood pressure or diabetes.
- Increase hypertension and diabetes awareness.
- Increase prediabetes awareness.
- Identify and promote community resources and programs for the prevention and control of high blood pressure, prediabetes, and diabetes.
- Implement policy or systems in health care settings that encourage a multi-disciplinary approach.

COUNTY DEMOGRAPHICS²

POPULATION 101,539 | MEDIAN HOUSEHOLD INCOME \$51,092 | PERSONS BELOW POVERTY LEVEL 17%



PARTNERS



ACTIONS

- ✓ Formed close partnership with Maintaining Active Citizens and Peninsula Regional Medical Center.
- ✓ Provided assistance to Peninsula Regional Medical Center and Maintaining Active Citizens in developing programs and collecting data.
- ✓ Oversaw home and community based services to prevent institutionalization of community members.
- ✓ Organized the flow and management of referrals throughout the partnership.
- ✓ Held monthly partner meetings to identify measures and strategies for capturing clinical and nonclinical data.
- ✓ Conducted self-management hypertension and diabetes workshops.
- ✓ Helped standardize health tools, such as referral forms, across all partners to facilitate patient care.

ACCOMPLISHMENTS

- 👑 91% of partnership referrals stayed out of the hospital after 30 days.
- 👑 Six master trainers and 32 leaders trained in hypertension module.
- 👑 52 individuals attended Diabetes Self-Management Program (DSMP) workshop.
- 👑 27 individuals attended Chronic Disease Self-Management Program (CDSMP) workshop.
- 👑 Held workshops at 17 different locations for community members.
- 👑 Patients given access to a level of expertise and coordination not available without partners' combined efforts.
 - Combination of hospital care, community health, and home care.
- 👑 Healthcare needs that were formerly being met by emergency departments now being met by partners.
- 👑 Four senior care staff certified in CDSMP and DSMP.

LESSONS LEARNED

- 💡 Formalize relations with an area agency on aging.
- 💡 Set realistic and attainable goals for initiatives.
- 💡 Ensure patients have a role and are engaged in their health.
- 💡 Recognize that partnerships are necessary in order to meet the broad needs of the community.
- 💡 Trust other organizations, counties, or catchment service areas and go where the need is, not just where the district lines are drawn.
- 💡 Issues cannot all be solved in a classroom or office, initiatives must have clinical components.
- 💡 Develop an integrated continuum of care.
- 💡 Train health care providers to be facilitators of care, directing community members to different community resources.

¹<http://dhmh.maryland.gov/ship/SitePages/Home.aspx>

²<http://quickfacts.census.gov/qfd/states/24/24037.html>

Partner Profile

Maintaining Active Citizens, Inc.

COMMUNITY PROGRAM

MAIN INITIATIVE: Chronic Disease Self-Management TARGET INTERVENTION: Hypertension, Diabetes & Prediabetes

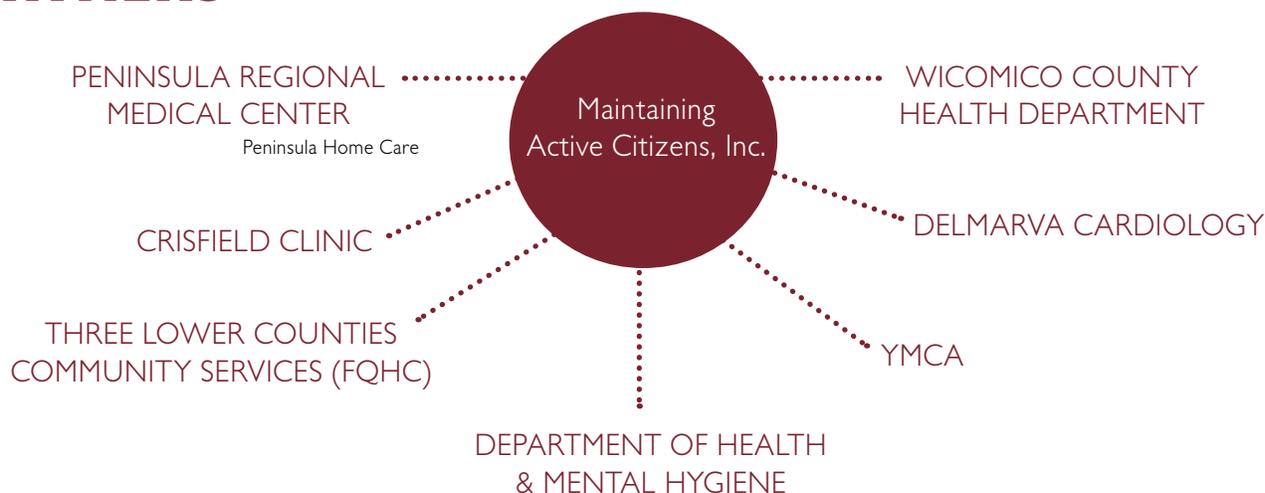
STRATEGIES

- Increase reporting, monitoring, and use of the following quality measures: NQF 18 (hypertension control) and NQF 59 (poor A1C control).
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- Improve treatment and follow up of persons with high blood pressure or diabetes.
- Establish formal referral systems linking at-risk patients identified in the community to follow up health care.
- Engage non-physician team members in hypertension and diabetes management in health care system.
- Increase hypertension and diabetes awareness.
- Increase prediabetes awareness.
- Identify and promote community resources and programs for the prevention and control of high blood pressure, prediabetes, and diabetes.
- Implement policy or systems in health care settings that encourage a multi-disciplinary approach.

ACTIONS

- ✓ Formed close partnership with Wicomico County Health Department and Peninsula Regional Medical Center.
- ✓ Took lead in training people in hypertension model.
- ✓ Hosted health fairs in partnership with YMCA.
- ✓ Helped standardize health tools, such as referral forms, across all partners to facilitate patient care.
- ✓ Engaged high risk patients for six weeks to monitor chronic disease.
- ✓ Participated and hosted hypertension screening events.
- ✓ Established bi-directional data sharing between partners.
- ✓ Promoted self-measured blood pressure monitoring.

PARTNERS



ACCOMPLISHMENTS

- 👑 91% of partnership referrals stayed out of the hospital after 30 days.
- 👑 Screened 234 individuals for hypertension at 19 different sites in 2015.
- 👑 Identified 119 people with hypertension.
- 👑 92% of participants saw improvement in blood pressure compared to their baseline measure.
- 👑 Identified 33 people with diabetes. (Q4)
- 👑 52 individuals attended Diabetes Self-Management Program (DSMP) workshop.
- 👑 27 individuals attended Chronic Disease Self-Management Program (CDSMP) workshop.
- 👑 Held community workshops at 17 different locations.
- 👑 Six master trainers and 32 leaders trained in hypertension module.
- 👑 Patients given access to a level of expertise and coordination not available without partners' combined efforts.
 - Combination of hospital care, community health, and home care.
- 👑 Healthcare needs that were formerly being met by emergency departments now being met by partners.
- 👑 Four senior care staff certified in CDSMP and DSMP.

LESSONS LEARNED

- 💡 Set realistic and attainable goals for initiatives.
- 💡 Ensure patients have a role and are engaged in their health.
- 💡 Recognize that partnerships are necessary in order to meet the broad needs of the community.
- 💡 Trust other organizations, counties, or catchment service areas and go where the need is, not just where the district lines are drawn.
- 💡 Issues cannot all be solved in a classroom or office, initiatives must have clinical components.
- 💡 Develop an integrated continuum of care.
- 💡 Train health care providers to be facilitators of care, directing community members to different community resources.

Partner Profile

Maryland Learning Collaborative

QUALITY IMPROVEMENT ORGANIZATION

MAIN INITIATIVE: Team-Based Care/Quality Improvement

TARGET INTERVENTION: Hypertension, Diabetes & Prediabetes

STRATEGIES

- Increase reporting, monitoring, and use of the following quality measures: NQF 18 (hypertension control) and NQF 59 (poor A1C control).
- Improve identification of undiagnosed persons with high blood pressure, prediabetes, and diabetes in clinical settings.
- Improve treatment and follow up of persons with high blood pressure or diabetes.
- Establish formal referral systems linking at-risk patients identified in the community to follow up health care.
- Engage non-physician team members in hypertension and diabetes management in health care system.
- Increase hypertension and diabetes awareness.
- Increase prediabetes awareness.
- Identify and promote community resources and programs for the prevention and control of high blood pressure, prediabetes, and diabetes.
- Implement policy or systems in health care settings that encourage a multi-disciplinary approach.

ACTIONS

- ✓ Recruited 21 primary care practices to participate in Million Hearts program.
- ✓ Standardized blood pressure monitoring among practice staff by providing hands on training.
- ✓ Provided education to practitioners on JNC 7 and JNC 8 guidelines.
- ✓ Encouraged practices to incorporate multiple metrics, patient lifestyle, and family in order to address chronic disease.
- ✓ Trained care managers on proper blood pressure screening, nutrition, and exercise strategies to combat chronic disease.
- ✓ Continually consult and educate practices on chronic disease management.

PARTNERS

21 PRIMARY CARE
PRACTICES

Maryland Learning
Collaborative

DEPARTMENT OF HEALTH
& MENTAL HYGIENE

ACCOMPLISHMENTS

- 👑 One primary care practice named “Million Hearts Champion.”
 - Increased hypertension control rate from 48% to 81% in two years.
- 👑 Identified 63% of patients with controlled hypertension at Million Hearts practices (NQF 18).
- 👑 5.3 readmission visits (30 day) per 1000 (median) at Million Hearts practices.
- 👑 Identified 25% of patients with diabetes who had A1c level greater than 9.0% at Million Hearts practices (NQF 59).
- 👑 Identified 71.1% of patients with diabetes who had A1c level less than 8.0% at Million Hearts practices (NQF 575).
- 👑 Via survey results: Eight out of ten responding practices refer patients to a diabetes self-management program.
- 👑 Via survey results: Six out of ten responding practices refer patients to a diabetes prevention program.
- 👑 72% of practices create a care plan for patients.
- 👑 Improvement of hypertension management through educating health providers and identifying best practices.

LESSONS LEARNED

- 💡 Practices must realize a benefit to participating in the program (income, improved outcomes, etc.).
- 💡 Must establish multiple levels of engagement with patients.
- 💡 Peer influence is important to encourage other practice groups to adopt team-based approaches to chronic disease management.
- 💡 Important to enhance team-based model to better serve community members.
- 💡 Cannot address one chronic disease in a vacuum. Must address the constellation of hypertension, diabetes, tobacco cessation, obesity, etc.
- 💡 Important to engage clinical practices to increase reach of initiatives.

Partner Profile

Medicaid

STATE MEDICAID OFFICE

MAIN INITIATIVE: Coordination of funding among MCOs

TARGET INTERVENTION: Hypertension & Diabetes

STRATEGIES

- Increase reporting, monitoring, and use of the following quality measures: NQF 18 (hypertension control) and NQF 59 (poor A1C control).
- Improve treatment and follow up of persons with high blood pressure or diabetes.
- Engage non-physician team members in hypertension and diabetes management in health care system.
- Increase hypertension and diabetes awareness.
- Increase prediabetes awareness.
- Identify and promote community resources and programs for the prevention and control of high blood pressure, prediabetes, and diabetes.
- Implement policy or systems in health care settings that encourage a multi-disciplinary approach.
- Use Health Information Technology to facilitate bi-directional data sharing to support care coordination and to improve health outcomes.

ACTIONS

- ✓ Set up Million Hearts Initiative grant offerings to MCOs.
- ✓ Awarded two grants to Amerigroup covering hypertension and diabetes.
- ✓ Awarded one grant to Riverside covering diabetes.
- ✓ Set parameters and reporting guidelines for grants.
 - Amerigroup's initiatives:
 - Educated members on prevention of chronic illness.
 - Disease management.
 - Expanded shared medical appointments.
 - Riverside's initiatives:
 - Conducted large informative mailer.
 - Developed educational text message campaign to members with diabetes.
 - Development of county-by-county directory of evidence based Diabetes Self-Management Programs.
 - Partnered with CVS to identify gaps in care related to medication management of diabetes.
 - Large scale outreach program.
 - Conducted educational webinar for providers on 2015 ADA Medical Care Standards for Diabetes.

PARTNERS

MANAGED CARE
ORGANIZATIONS (MCOs)

Amerigroup Community Care
Riverside Health of Maryland

Medicaid

DEPARTMENT OF HEALTH
& MENTAL HYGIENE

ACCOMPLISHMENTS

- 👑 Riverside conducted webinar with over 50 providers.
- 👑 Amerigroup has reached 164 patients through shared medical appointments.
- 👑 90 people participated in Amerigroup's first two shared medical appointments.
- 👑 Amerigroup (projected accomplishments- final report pending)
 - Develop and implement four new shared medical appointments to serve 80 members in Baltimore City and Prince George's County.
 - Train six internal staff and four external partner staff members to become registered health coaches.
 - Increase percent of providers that utilize evidence based guidelines.
 - Improve diabetes (NQF 59) and blood pressure control (NQF 18) for 60% of attendees.
 - Increase the percent of members that report that they feel more confident in managing their chronic illness.
- 👑 Riverside (projected accomplishments- final report pending)
 - At least 50 primary care providers attend webinars.
 - Decrease pharmaceutical gaps in care by 25%.
 - Outreach to 100% of members with diabetes to encourage participation in self-management program.
 - 150 members with diabetes attend an evidence-based diabetes self-management class.
 - 50% of members that fall into Comprehensive Diabetes Care HEDIS denominator receive an A1c test prior to 6/1/2015.

LESSONS LEARNED

- 💡 Adjust timing of RFP to encourage more applicants.
- 💡 Provide more details and direction in grant offering.
- 💡 Overall timeframe of grant is insufficient.

Partner Profile

Peninsula Regional Medical Center

HEALTH SYSTEMS/PRACTICE (275-bed capacity)

MAIN INITIATIVE: Chronic Disease Self-Management

TARGET INTERVENTION: Hypertension, Diabetes & Prediabetes

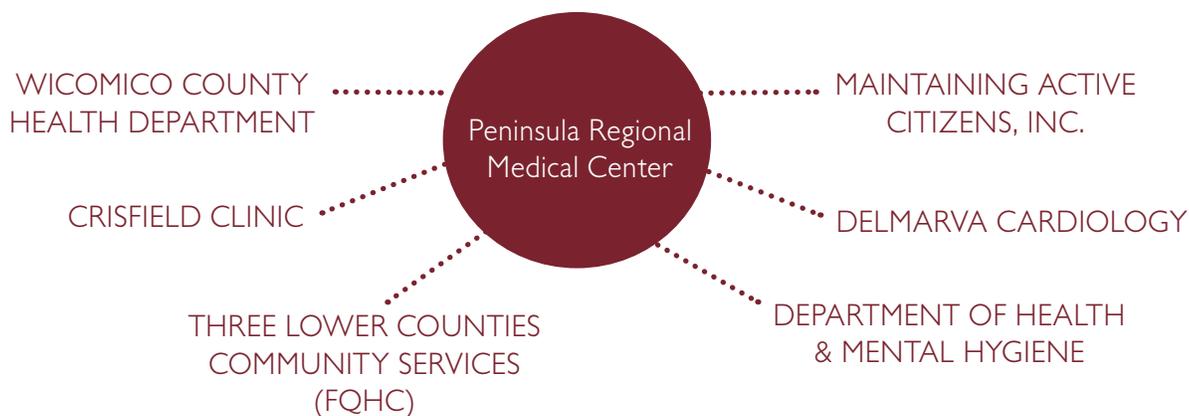
STRATEGIES

- Increase reporting, monitoring, and use of the following quality measures: NQF 18 (hypertension control) and NQF 59 (poor A1C control).
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- Improve treatment and follow up of persons with high blood pressure or diabetes.
- Establish formal referral systems linking at-risk patients identified in the community to follow up health care.
- Engage non-physician team members in hypertension and diabetes management in health care system.
- Increase hypertension and diabetes awareness.
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- Identify and promote community resources and programs for the prevention and control of high blood pressure, prediabetes, and diabetes.
- Implement policy or systems in health care settings that encourage a multi-disciplinary approach.

ACTIONS

- ✓ Formed close partnership with Maintaining Active Citizens and Wicomico County Health Department.
- ✓ Hosted self-management hypertension and diabetes workshops.
- ✓ Track participants for seven weeks to monitor hypertension.
- ✓ Hosted chronic disease screening events and workgroups for community members.
- ✓ Provided community healthcare workers and senior care workers through Peninsula Home Care.
- ✓ Cross trained senior care workers in chronic disease management.
- ✓ Established health data collection system for partnership.
- ✓ Helped standardize health tools, such as referral forms, across all partners to facilitate patient care.
- ✓ Oversaw initial patient visits and assigned community health workers

PARTNERS



ACCOMPLISHMENTS

- 👑 91% of partnership referrals stayed out of the hospital after 30 days.
- 👑 Screened 131 individuals for diabetes. (Q4)
- 👑 Reviewed A1c levels of 43 individuals. (Q4)
- 👑 Identified 20 individuals with A1c level greater than 9.0%. (Q4)
- 👑 Referred 20 individuals identified with diabetes to primary care. (Q4)
- 👑 Screened 131 individuals for hypertension. (Q4)
- 👑 Identified 72 individuals with hypertension. (Q4)
- 👑 Identified 44 individuals with controlled hypertension. (Q4)
- 👑 Referred 20 individuals to primary care. (Q4)
- 👑 52 individuals attended Diabetes Self-Management Program (DSMP) workshop.
- 👑 27 individuals attended Chronic Disease Self-Management Program (CDSMP) workshop.
- 👑 Peninsula Home Care
 - Identified 70 individuals with hypertension.
 - 69.2% of participants saw improvements in blood pressure.
 - Identified 15 individuals with A1c level greater than 9.0%.
- 👑 Held community workshops at 17 different locations.
- 👑 Six master trainers and 32 leaders trained in hypertension module.
- 👑 Patients given access to a level of expertise and coordination not available without partners' combined efforts.
 - Combination of hospital care, community health, and home care.
- 👑 Development of multiple tools for monitoring, referring, and tracking patients.
- 👑 Healthcare needs that were formerly being met by emergency departments now being met by partners.
- 👑 Four senior care staff certified in CDSMP and DSMP.

LESSONS LEARNED

- 💡 Formalize relations with an area agency on aging.
- 💡 Set realistic and attainable goals for initiatives.
- 💡 Ensure patients have a role and are engaged in their health.
- 💡 Recognize that partnerships are necessary in order to meet the broad needs of the community.
- 💡 Trust other organizations, counties, or catchment service areas and go where the need is, not just where the district lines are drawn.
- 💡 Issues cannot all be solved in a classroom or office, initiatives must have clinical components.
- 💡 Develop an integrated continuum of care.
- 💡 Train health care providers to be facilitators of care, directing community members to different community resources.

Partner Profile

Mid-Atlantic Association of Community Health Centers

QUALITY IMPROVEMENT ORGANIZATION

MAIN INITIATIVE: Community Care Informatics Center (in development).

TARGET INTERVENTION: Health data on hypertension, diabetes & prediabetes

HEALTH STATISTICS¹

+ PERCENT OF PATIENTS WITH MEDICAL CONDITIONS: Hypertension 26.2%, Diabetes 11.6%

STRATEGIES

- Increase reporting, monitoring, and use of the following quality measures: NQF 18 (hypertension control) and NQF 59 (poor A1C control).
- Use Health Information Technology to facilitate bi-directional data sharing to support care coordination and to improve health outcomes.

ACTIONS

- ✓ Utilize Azara Healthcare and i2i Systems to collect data from each FQHC.
- ✓ Established a CCIC Advisory Council consisting of members from every FQHC in Maryland.
- ✓ Gathered information to standardize measures and definitions across all FQHCs.
- ✓ Validate data to ensure partner data matches reporting parameters.

PARTNERS



ACCOMPLISHMENTS

- 👑 Increased collaboration among health centers.
- 👑 Coordinated reporting measures and definitions among health centers.
- 👑 Identified vendor to assist with data aggregation.
- 👑 Defined reporting parameters among health centers.
- 👑 Identified health centers to participate in beta testing.
- 👑 Executed four participation agreements among FQHCs.

LESSONS LEARNED

- 💡 Must balance the interests of each individual FQHC.
- 💡 Must budget ample time into schedule in order to accomplish a major systems change.
- 💡 Must protect the proprietary and patient information of each FQHC.

¹Statistics on Maryland patients in 2013 according to the MACHC Snapshots handbook