Quality Insights

Navigating the Path to Wellness: Team-Based Strategies for Hypertension Control

The National Cardiovascular Health Program

Joe Pinto, Jr., CHITP, CMAP, Practice Transformation Specialist

Housekeeping Notes

- All attendee lines are muted.
- Please submit your questions to our panelists via the Q&A feature.
- Questions will be addressed at the end of the session as time permits.

Quality Insights Overview

- A non-profit organization focused on data-driven community solutions to improve health care quality in pursuit of better care, smarter spending, and healthier people.

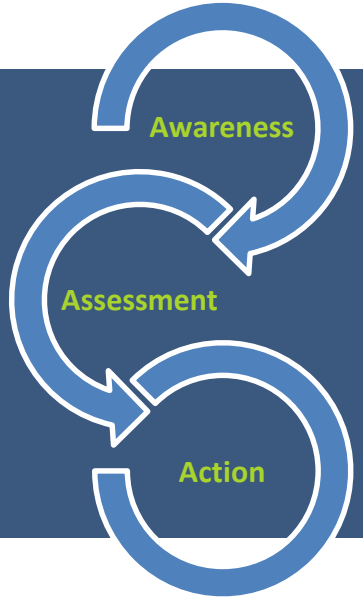
- Change agent, trusted partner, and integrator of organizations collaborating to improve care.

Purpose

- Overview of evidence-based information
  - Cardiovascular health and prevention and management of hypertension
    - Awareness
    - Assessment
    - Action

Hypertension Management

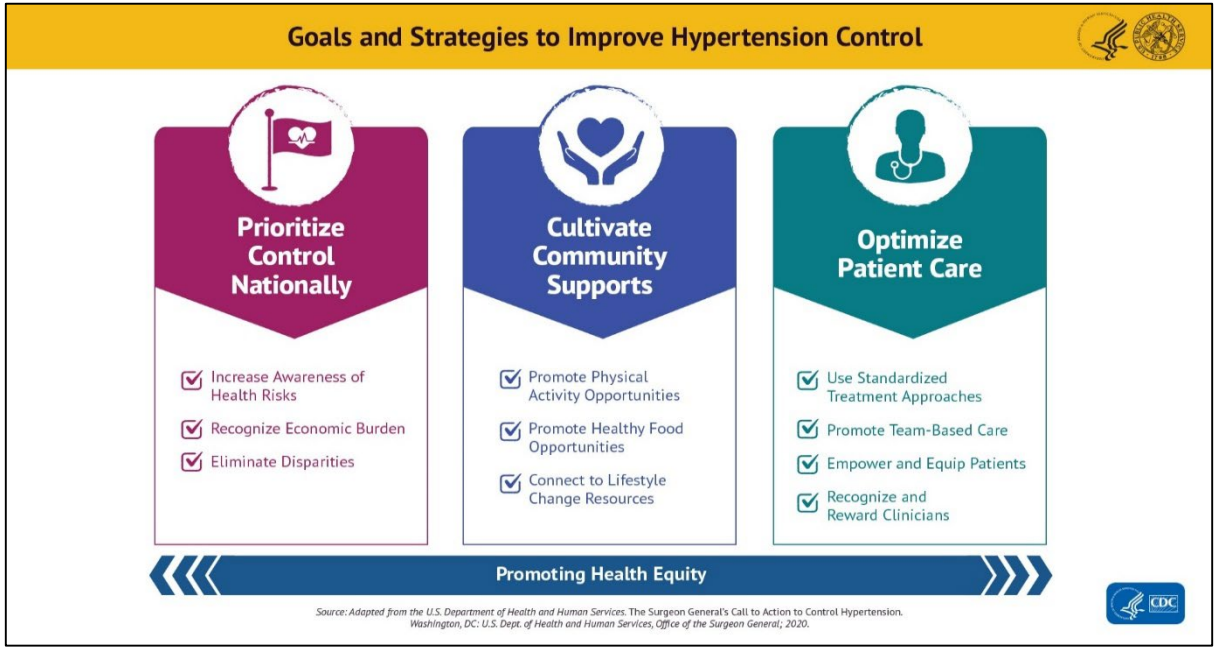
Awareness: Control is the Goal



Surgeon General's Call to Action

From *Partner Toolkit*, by Centers for Disease Control and Prevention, 2022.

Goals & Strategies to Improve Hypertension Control



From *Partner Toolkit*, by Centers for Disease Control and Prevention, 2022.

"For an adult 45 years of age without hypertension, the 40-year risk for developing hypertension is 93% for African Americans, 92% for Hispanics, 86% for whites, and 84% for Chinese adults."[1]

In Pennsylvania:

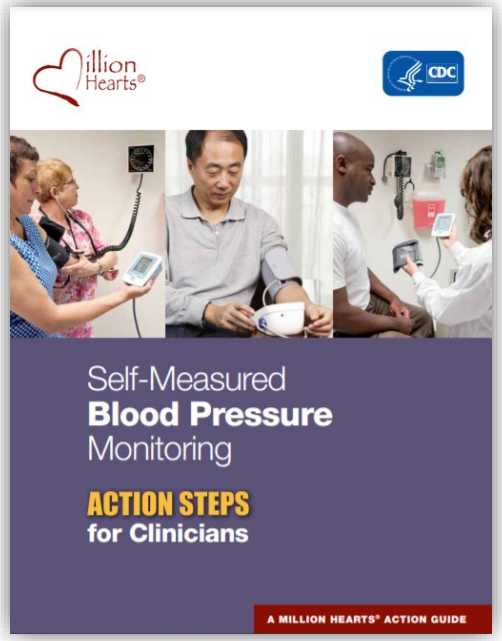
1 in 3 adults have high blood pressure.[2]

Sources: [1]Rubenfire, 2018; [2] PA Department of Health, 2021.

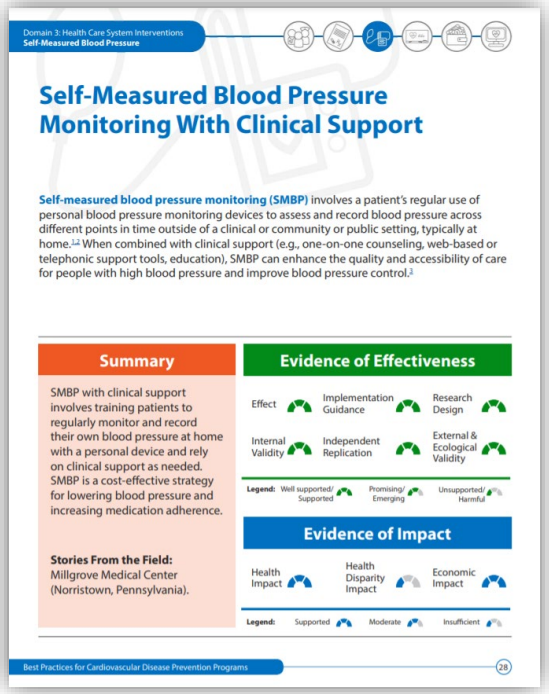
TARGET: BP™

- The **Target: BP Recognition Program** celebrates physician practices and health systems, who treat patients with hypertension, for achieving blood pressure (BP) control rates at or above 70% within the populations they serve.
  - 2024 registration deadline: **May 17, 2024 at 11:59 p.m. EST**
- Join hundreds of other organizations committed to improving BP control rates and gain access to:
  - BP Improvement Support
  - Self-Measured BP (SMBP)
  - BP Guidelines
  - Tools
- Reference resource for care teams - Target: BP™ Combined Quick Start Guides
- Webinar: Evolving SMBP Policy and Practice

Million Hearts®



U.S. Public Health Service 1798



U.S. Department of Health & Human Services • USA

AHRQ Advancing Excellence in Health Care

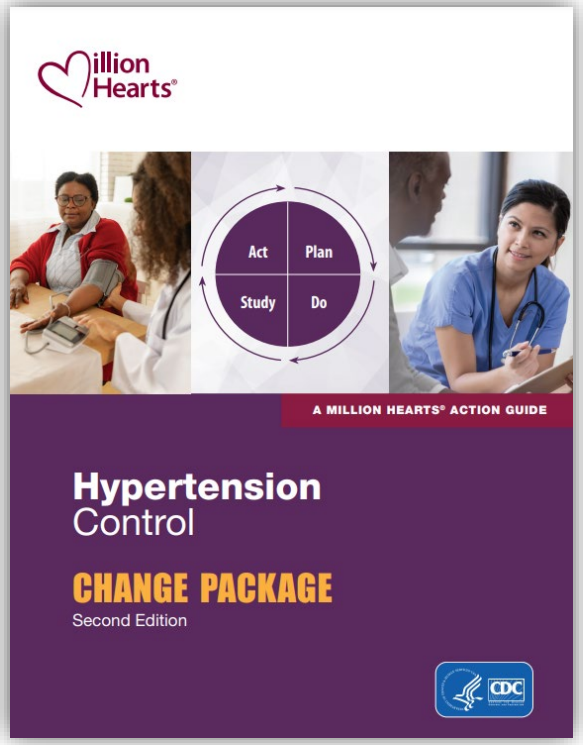
U.S. Preventive Services TASK FORCE

CDC

Million Hearts®

- Hypertension Control Change Package (HCCP), Second Edition

The HCCP is broken down into four main focus areas:

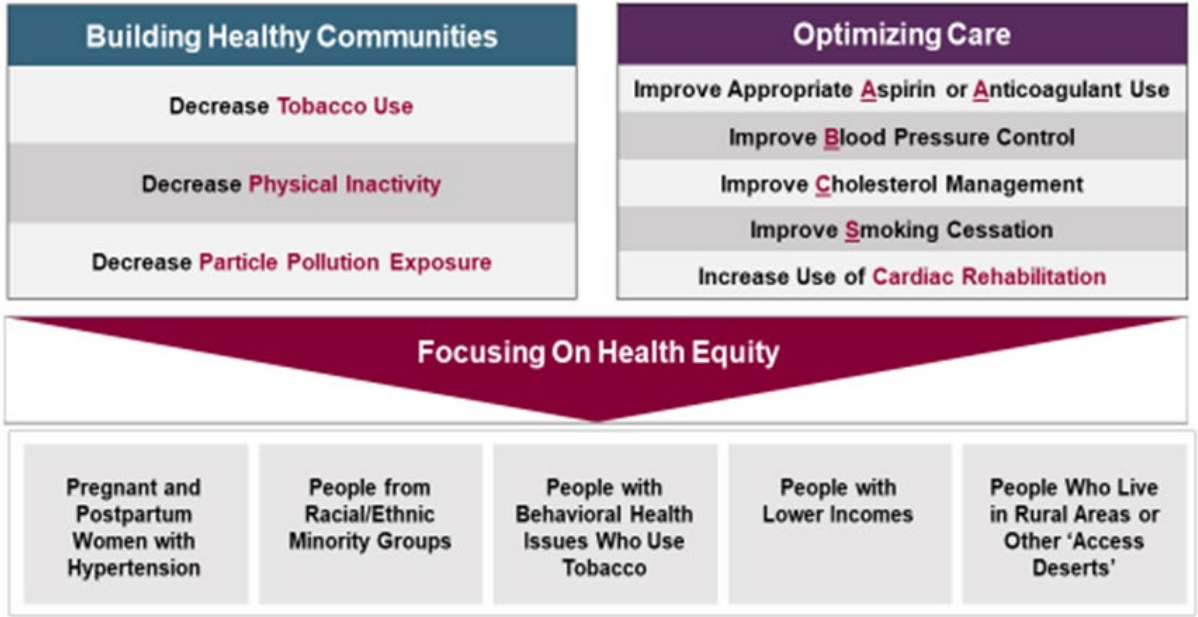


Million Hearts®

- Aiming to prevent 1 million cardiovascular events by December 2026, Million Hearts® 2027 seeks strong and specific commitments so we can improve cardiovascular health for all.

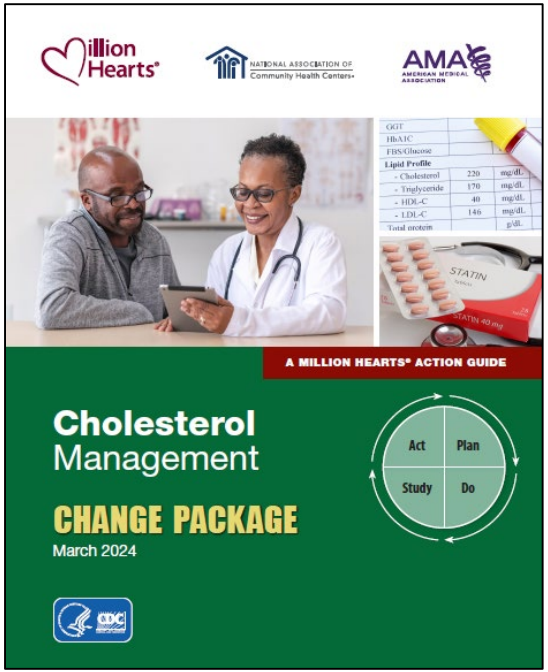
Source: Million Hearts®, 2024.

Million Hearts® 2027 Priorities



Source: Million Hearts®, 2023.

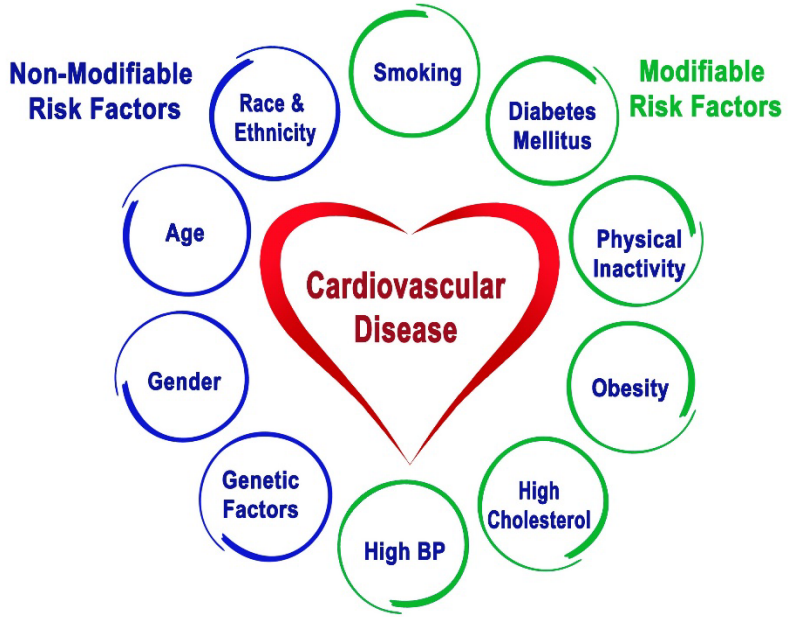
Cholesterol Management Change Package



- Cholesterol screening – non-fasting
- Statin and non-statin therapies
- “Hiding in plain sight”
- Familial hypercholesterolemia
- Shared decision making
- Social drivers of health

Download the Cholesterol Management Change Package.

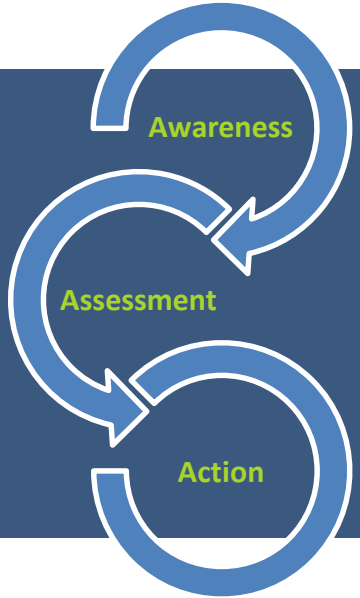
Risk-enhancing Factors



- Health conditions including:
  - Metabolic syndrome
  - Chronic kidney disease
  - Chronic inflammatory conditions
  - Premature menopause
  - Preeclampsia
  - High lipid biomarkers

Hypertension Management

Assessment: Knowing the Numbers - Using the Tools



ACC/AHA Guidelines

Categories of BP in Adults*

BP Category	SBP		DBP
Normal	<120 mm Hg	and	<80 mm Hg
Elevated	120–129 mm Hg	and	<80 mm Hg
Hypertension			
Stage 1	130–139 mm Hg	*or*	80–89 mm Hg
Stage 2	≥140 mm Hg	*or*	≥90 mm Hg

*Individuals with SBP and DBP in 2 categories should be designated to the higher BP category.

Table 6

From "2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: Guidelines Made Simple, A Selection of Tables and Figures," by ACC/AHA Task Force on Clinical Practice Guidelines, 2017.

Clinical Support: Key to Sustained Success

- Strong evidence for SMBP when combined with clinical support
- Significant improvements in BP compared to usual care
- Sustained up to 12 months

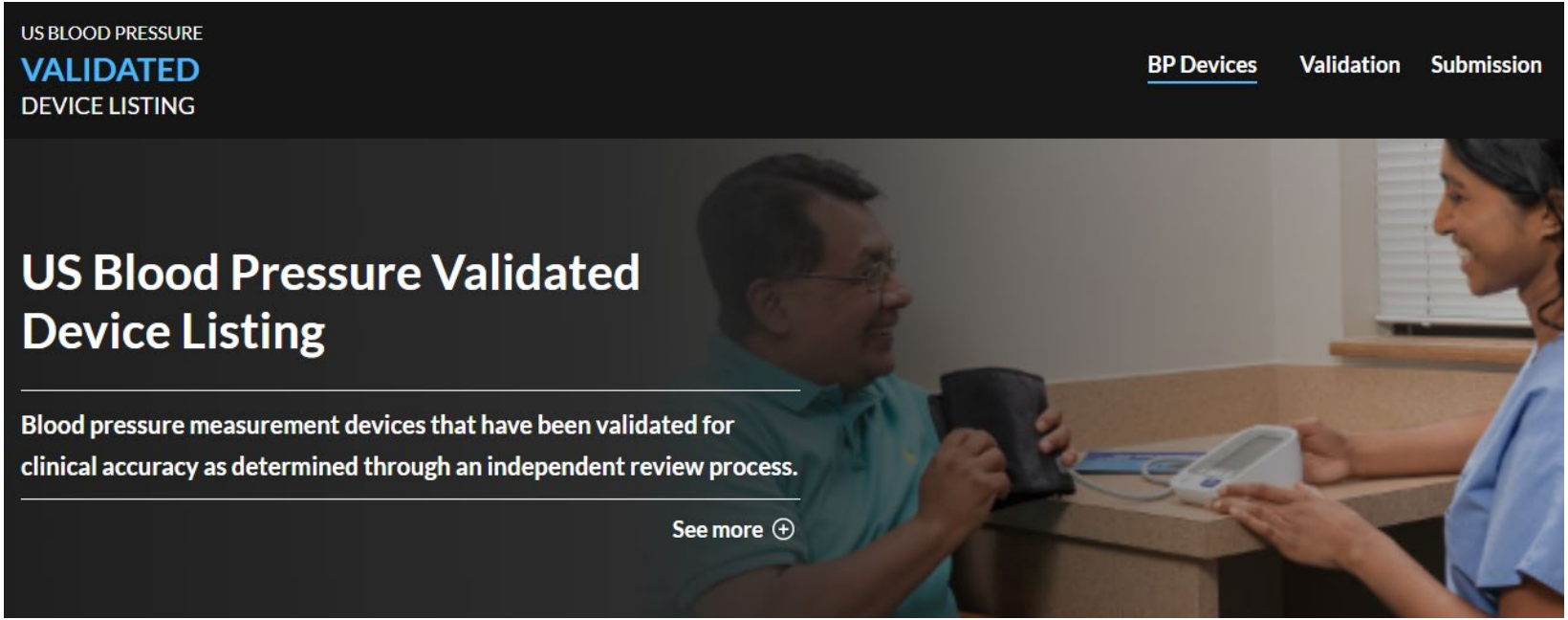
Source: Community Preventive Task Force, 2017.

SMBP with Clinical Support

- Regular BP measurement by patient
- Increases awareness of BP control
- Promotes medication adherence

Source: CDC, 2023.

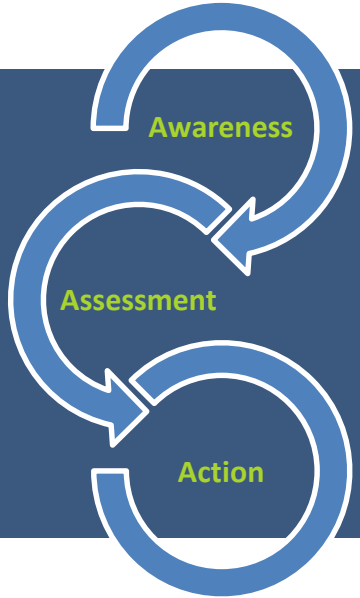
ValidateBP.org



Source: "US Blood Pressure Validated Device Listing," by American Medical Association, n.d.

Hypertension Management

Action: Improving Health Across the Lifespan



Lifestyle Change Programs

Resources

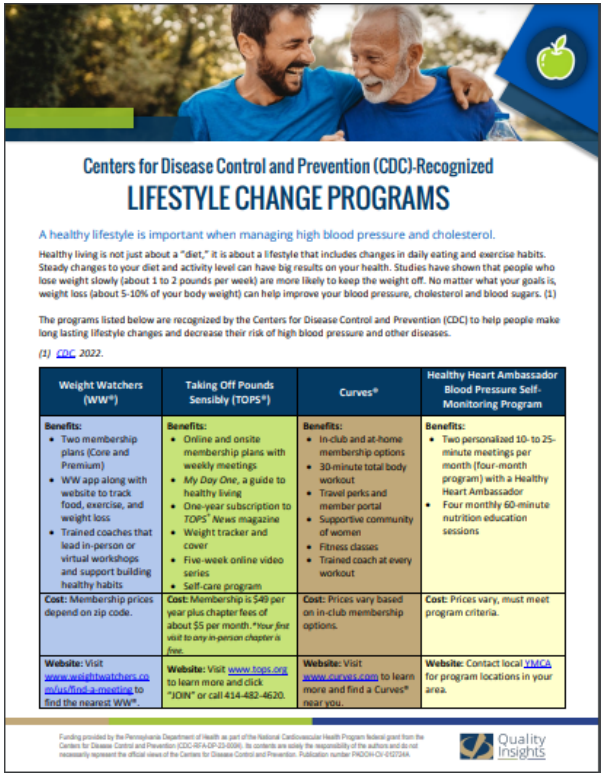
- PA DOH Quitline - for tobacco cessation
- CardioSmart Patient Fact Sheets
- AHA's Life's Simple 7

CDC Recommendations

- YMCA Blood Pressure Self-Monitoring Program
- The National Healthy Heart Ambassador Blood Pressure Self-Monitoring (HHA-BPSM) program
- Supplemental Nutrition and Assistance Program (SNAP)
- Expanded Food and Nutrition Education Programs (EFNEP)

Lifestyle Change Programs in PA

- YMCA's Blood Pressure Self-Monitoring Program
- Taking Off Pounds Sensibly (TOPS)
- Curves Complete
- Weight Watchers (WW®)
- EFNEP
- SNAP-Ed



Centers for Disease Control and Prevention (CDC)-Recognized

LIFESTYLE CHANGE PROGRAMS

A healthy lifestyle is important when managing high blood pressure and cholesterol.

Healthy living is not just about a "diet," it is about a lifestyle that includes changes in daily eating and exercise habits. Steady changes to your diet and activity level can have big results on your health. Studies have shown that people who lose weight slowly (about 1 to 2 pounds per week) are more likely to keep the weight off. No matter what your goals is, weight loss (about 5-10% of your body weight) can help improve your blood pressure, cholesterol and blood sugars. (1)

The programs listed below are recognized by the Centers for Disease Control and Prevention (CDC) to help people make long lasting lifestyle changes and decrease their risk of high blood pressure and other diseases.

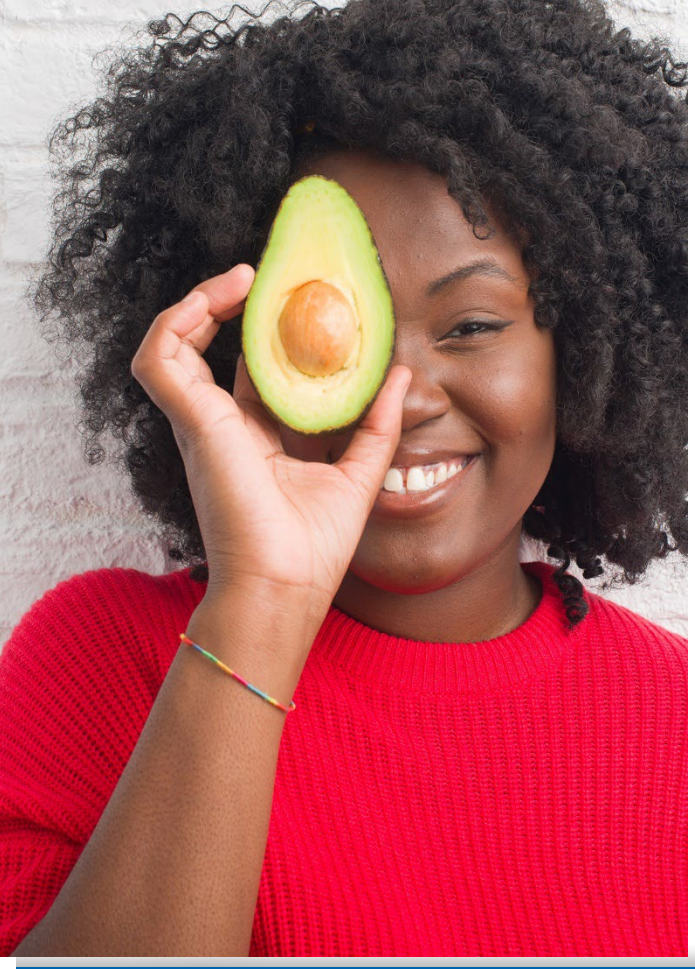
(1) CDC. 2022.

Weight Watchers (WW®)	Taking Off Pounds Sensibly (TOPS®)	Curves®	Healthy Heart Ambassador Blood Pressure Self-Monitoring Program
Benefits: • Two membership plans (Core and Premium) • WW app along with website to track food, exercise, and weight loss • Trained coaches that lead in-person or virtual workshops and support building healthy habits	**Benefits:** • Online and onsite membership plans with weekly meetings • *My Day One*, a guide to healthy living • One-year subscription to *TOPS® News* magazine • Weight tracker and cover • Five-week online video series • Self-care program	**Benefits:** • In-club and at-home membership options • 30-minute total body workout • Travel perks and member portal • Supportive community of women • Fitness classes • Trained coach at every workout	**Benefits:** • Two personalized 10- to 25-minute meetings per month (four-month program) with a Healthy Heart Ambassador • Four monthly 60-minute nutrition education sessions
Cost: Membership prices depend on zip code.	**Cost:** Membership is $49 per year plus chapter fees of about $5 per month. **Your first visit to any in-person chapter is free.*	**Cost:** Prices vary based on in-club membership options.	**Cost:** Prices vary, must meet program criteria.
Website: Visit www.weightwatchers.com/us/find-a-meeting to find the nearest WW®.	**Website:** Visit www.tops.org to learn more and click "JOIN" or call 414-482-4620.	**Website:** Visit www.curves.com to learn more and find a Curves® near you.	**Website:** Contact local YMCA for program locations in your area.

Funding provided by the Pennsylvania Department of Health as part of the National Cardiovascular Health Program federal grant from the Centers for Disease Control and Prevention (CDC-RFA-DP-23-0006). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention. Publication number PADOH-CH-0127244.

Quality Insights

Download the flyer.



Patient Education Resources

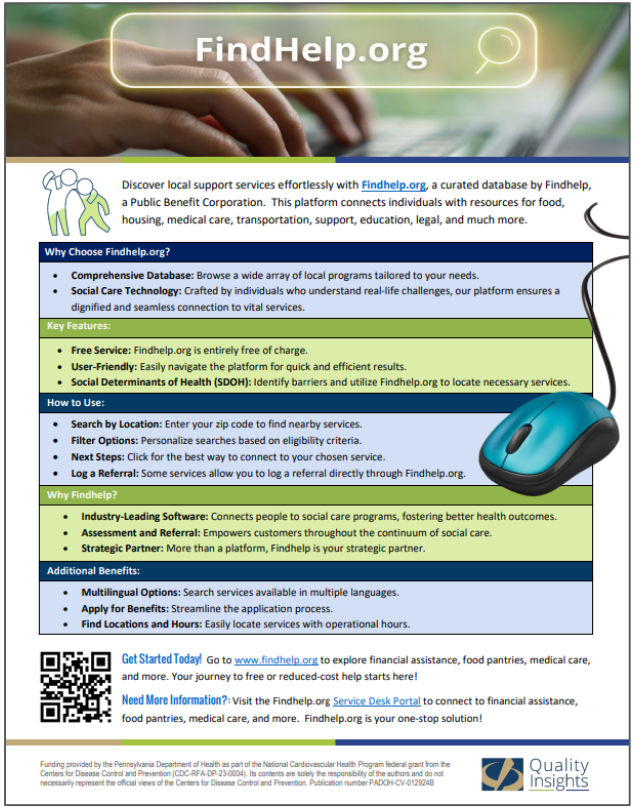
- DASH Eating Plan
- AHA's Get the Scoop on Sodium and Salt
- AHA Life's Simple 7
- AHA's 5 Steps to Quit Smoking and Vaping
- Blood Pressure Fact Sheets

Health Disparities: Considerations for Underserved Populations

- Assess social context, including food insecurity, housing stability, and financial barriers.
- Partner with and support community champions who target underserved populations.
- Share opportunities for self-management support community resources when available.
- Provide educational materials in multiple languages and appropriate literacy levels.

PA Navigate Powered by FindHelp.org

- This is an online tool to connect all Pennsylvanians with community-based organizations and for referrals to resources to meet their needs.
  - Examples: Food, shelter, and transportation



Download the flyer here.

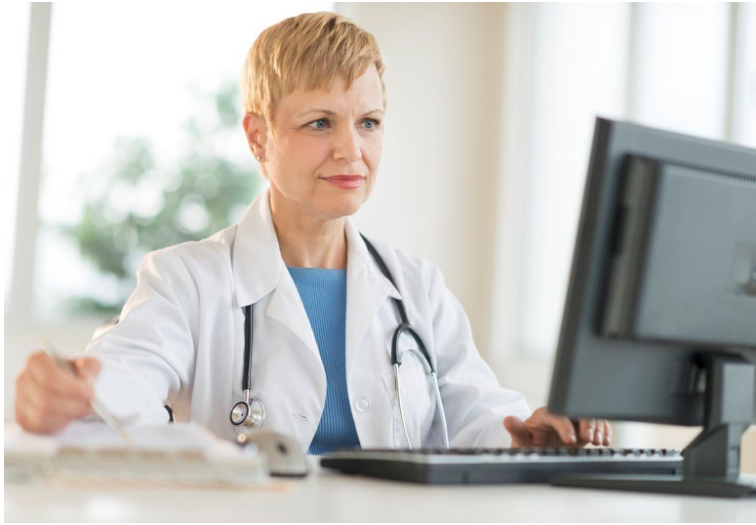
Workflow Modifications Your Practice Can Implement to Improve Hypertension Management

Leveraging Care Teams for Optimal Outcomes

- Create a clear clinical workflow that incorporates the entire care team.
- Contact your Quality Insights Practice Transformation Specialist for assistance.

Your EHR and You: 3 Tips for Improved Cholesterol Management

1. Mind your measures.
2. Document referrals in structured data fields.
3. Utilize EHR alerts.



Workflow Modifications: EHR Actions

- Run a registry report of patients with elevated BP >140/90.
- Assess EHR capability to run reports for clinical quality measure CMS165v12.
- Determine ability to report race/ethnicity levels for priority populations.
- Develop and implement structured data fields, track lifestyle change program referrals, and ensure feedback is received.

Workflow Modifications: Protocol and Workflow Actions

- Treat hypertension using current guidelines-based medical management recommendations. Develop a practice protocol that spans all sites within your practice.
- Schedule follow-up appointments every 2-3 weeks until BP is in control, then every 6 months thereafter.
- Evaluate medication adherence and efficacy at 4-12 weeks using a fasting lipid test. Retest every 3-12 months as needed.
- Use the ACC ASCVD Risk Estimator Plus.
- Order a Coronary Artery Calcium Test. The results can assist patients >=40 years old with uncertain risk status in shared decision making.

Workflow Modifications: Practice and Clinical Staff Actions

- Assign a Hypertension Champion.
- Develop a protocol for hypertension management.
- Implement a team-based care management plan for high blood pressure.
- Integrate the ACC ASCVD Risk Test into your organization's EHR.
- Promote lifestyle change program offerings and referrals.

Workflow Modifications: Patient Education Actions

- Encourage heart-healthy lifestyles including physical activity, weight reduction and maintenance, smoking cessation, and controlling diabetes.
- Promote lifestyle improvement using CDC-approved resources and referral sources.

In Conclusion

- Evidence-based information for cardiovascular health and hypertension management
- Risk-enhancing factors of hypertension management
- Actions for improving cardiovascular health and hypertension management
- Importance of lifestyle change programs
- Workflow modifications, protocols, and actions

Today's Guest Panelists

PA Pharmacists Care Network

Expertly Managing Your Medications, Focusing on You.

the YMCA

HARRISBURG AREA YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Pennsylvania Pharmacists Care Network (PPCN)

Stephanie Harriman McGrath, PharmD
Executive Director, PPCN

Kelsey Hake, PharmD
Director of Engagement, PPCN

Leveraging Community Pharmacies to Support Longitudinal Patient Care

Stephanie McGrath, PharmD | Executive Director
Kelsey Hake, PharmD | Director of Engagement

PA Pharmacists Care Network

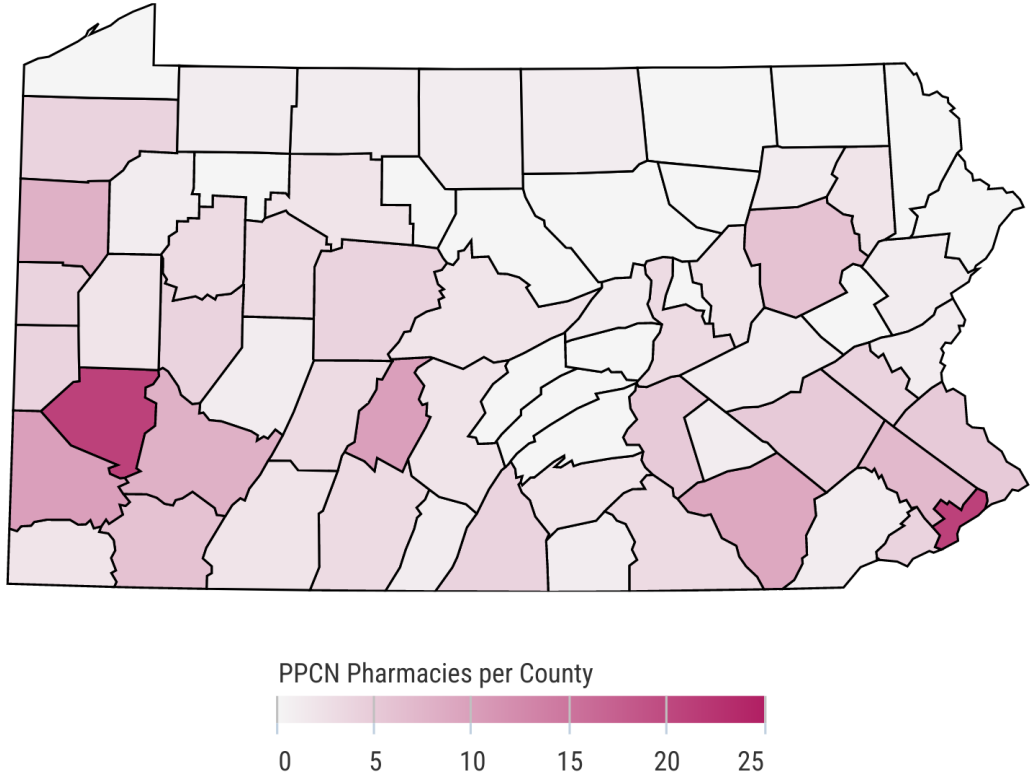
Expertly Managing Your Medications, Focusing on You.

202

COMMUNITY PHARMACIES ACROSS

51

COUNTIES



Our Network

Mission: To enable and support the **delivery of quality pharmacy care** and **outcomes** in **collaboration** with patients, practitioners and stakeholders involved in a **patient's care**.

PA Pharmacists Care Network

Expertly Managing Your Medications, Focusing on You.

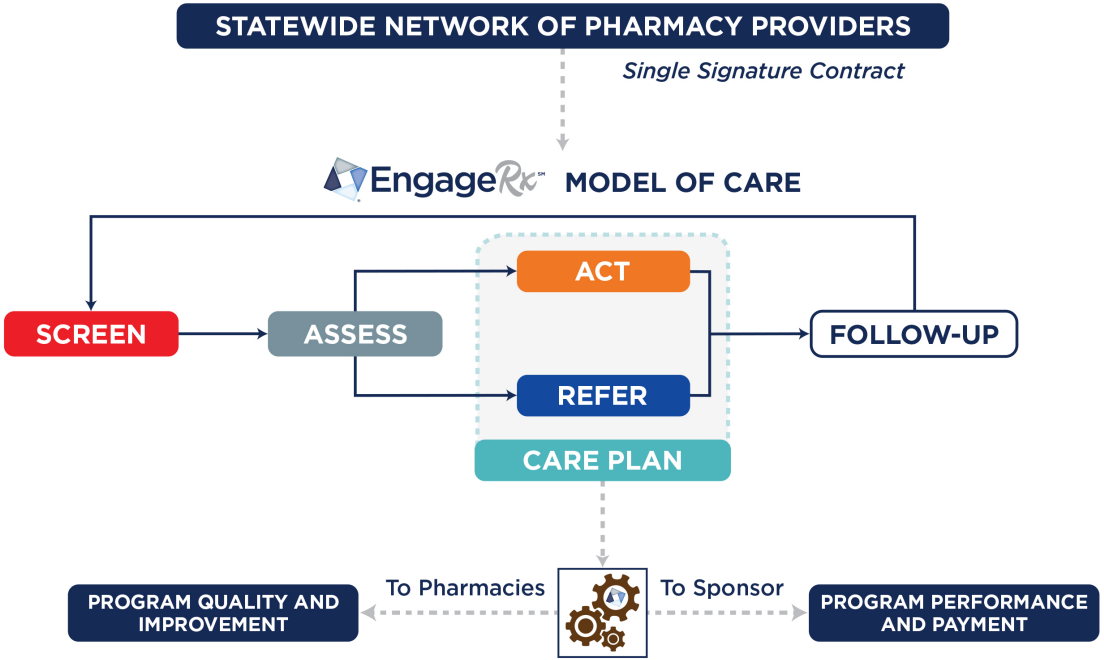
Vision: Pharmacists and pharmacies will be **leaders** in the promotion of **healthy communities** through **innovations in health and pharmacy care**.

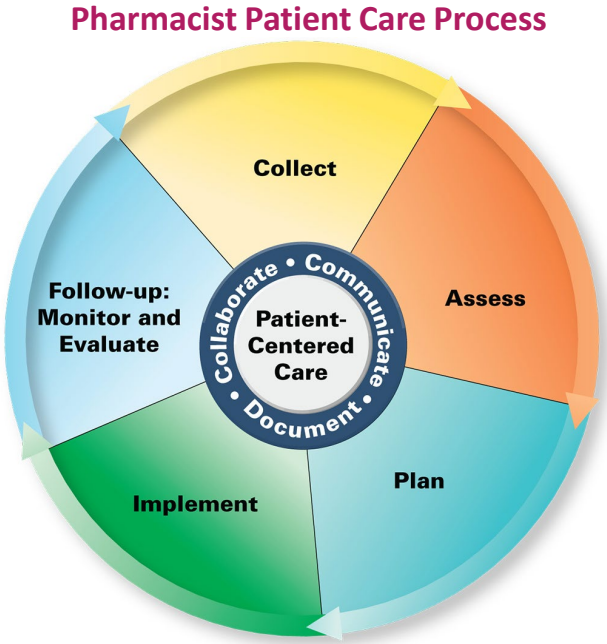
Leveraging Community Pharmacies to Support Longitudinal Patient Care

- Community pharmacies are poised to provide longitudinal patient care services because of their accessibility and frequency with which they interact with their patients
- Community pharmacies can serve as extenders of the care team and ensure care coordination between the pharmacy, the patient's primary care provider, the patient's health plan, and more

Gaskins RE. "Innovating Medicaid: the North Carolina Experience." North Carolina Medical Journal. January-February 2017;78(1): 20-24.

Service Provision Goes Far Beyond Medication Dispensing





Joint Commission of Pharmacy Practitioners. Pharmacists' Patient Care Process. May 29, 2014. Available at: https://jcpp.net/wp-content/uploads/2016/03/PatientCareProcess-with-supporting-organizations.pdf.

Enhanced Patient Care Services Being Provided by Community Pharmacists to Medicaid Patients

Monthly Hypertension Encounters

Monthly Diabetes Encounters

Social Determinants of Health Screenings and Referral

Home Hand Delivery & Home Visits

Medication Synchronization, Medication Adherence Packaging, & Medication Reconciliation

Monthly Asthma and COPD Encounters

Medication Management and Adherence Support Services

- Patients are nonadherent to their medications approximately 50% of the time. In conditions where symptoms aren't often felt, like hypertension, nonadherence can rise up to 80%.[3]
- Medication nonadherence leads to poor outcomes, increasing healthcare service utilization and overall healthcare costs.
- Medication nonadherence is estimated to lead to between $100 and $300 billion of avoidable healthcare costs in the United States annually, representing 3–10% of total U.S. healthcare costs.[4]

3) Brown MT, Bussell J, Dutta S, Davis K, Strong S, Mathew S. Medication Adherence: Truth and Consequences. Am J Med Sci. 2016 Apr;351(4):387-99. doi: 10.1016/j.amjms.2016.01.010. PMID: 27079345.
4) IMS Institute for Healthcare Informatics. Avoidable costs in US health care. 2013. Available from: http://www.imshealth.com/deployedfiles/imshealth/Global/Content/Corporate/IMS%20Institute/.RUOM-2013/IHII_Responsible_Use_Medicines_2013.pdf. Accessed May, 2015.

Medication Management and Adherence Support Services

- Medication synchronization has been shown to improve adherence and decrease costs in Medicaid patients on chronic medications.[5]
- Adherence packaging has the ability to improve medication adherence, increase their confidence in medication management, and improve perceived quality of life.[6,7]
- Home hand delivery services are intended to solve for transportation barriers and is a key strategy many community pharmacies use to address Social Determinants of Health gaps

Photo is property of ACORx Pharmacy: https://acorxpharmacy.com/

5) Datar M, Banahan BF, Hardwick S, et a. Analysis of the impact of prescription synchronization on adherence among Medicaid beneficiaries. *Value Health*. 2013;16:A1-A298
6) Nair P, Kee KW, Mah CS, Lee ES. Evaluating lthe Impact of Outpatient Multi-Dose Medication Packaging Service (MDMPS) on Medication Adherence and Clinical Outcomes. J Prim Care Community Health. 2020 Jan-Dec;11:2150132720965085. doi: 10.1177/2150132720965085. PMID: 33089747; PMCID: PMC7585883.
7) Phi C, Berenbrok LA, Carroll JC, Firm A, McGivney MS, Coley KC. Impact of a Medication Adherence Packaging Service on Patient-Centered Outcomes at an Independent Community Pharmacy. Pharmacy (Basel). 2021 Jan 5;9(1):11. doi: 10.3390/pharmacy9010011. PMID: 33466499; PMCID: PMC7838800.

Social Determinants of Health Screening & Referral in Community Pharmacy

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Social Determinants of Health Screening & Referral in Community Pharmacy

PA Pharmacists Care Network | CPESN

SDOH Screening

Identifying and Meeting SDOH Needs

Social Determinant of Health (SDOH) Screening

- The pharmacist or pharmacy staff will screen patients for social determinants of health, assess for medication complexity findings, and refer to community or patient resources.
- The pharmacist or pharmacy staff will refer patient to appropriate community resources and/or to care management.
- The pharmacist or pharmacy staff will document screening and follow up in pharmacy care plan.

Pharmacies screen patients for needs related to food, financial, housing, transportation, child care, clothing and employment insecurity.

Program Success Stories

"A 63 year old female with multiple health conditions was administered the SDOH screening tool. She had limited access to transportation, housing issues, low income, and little to no food. She had one can of chili, one bag of popcorn, and a can of coffee to last her through the weekend. She has also been experiencing some knee pain that makes it difficult to walk/stand for long periods of time. She's been struggling with trying to quit smoking. The pharmacy team was able to find many resources for her including transportation, a variety of food banks, a list of grocery stores that offer delivery, and a smoking cessation program. She seemed grateful that someone was willing to help her and thanked us for taking the time to talk with her."

"Our pharmacy team spoke with a patient in September to complete the SDOH screening and Health Risk Assessment. While completing these assessments, the patient had expressed she needed some resources for "Section 8" housing. We gave her the resource, and made a referral for Section 8 Housing Choice Vouchers by the Housing Authority of the City of Pittsburgh (HACP).

Follow up was placed 3 months later in December. The patient stated things were going well and she was excited to share that she was moving to Section 8 housing this week thanks to the referral we made 3 months ago. The referral for Section 8 housing was a success, and the patient was very thankful."

"I spoke to a patient to offer an SDOH screening and referral, and during the first conversation the patient claimed they did not need any resources. The patient called back later in the day, after she was done with work, and expressed that she did need resources but she was embarrassed to ask in front of her colleagues at work. I gave her the resources she needed for places to find jobs, and she was very thankful.

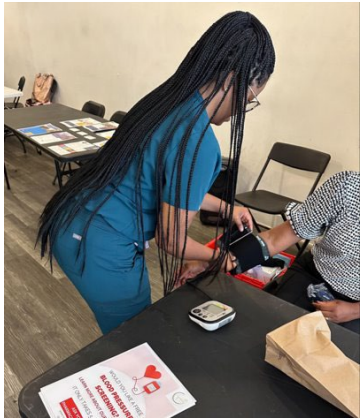
Three months later during a follow up to reassess the SDOH screening, the patient stated that the resources given to the her during the September call had helped her find a job and she was no longer in need of any resources."

Meeting patients where they are to identify SDOH needs and successfully match to community resources to meet those needs.

Pennsylvania Pharmacists Care Network, 2023

Hypertension Management Services in Community Pharmacy

- Medicaid patients with a hypertension diagnosis will be eligible for monthly hypertension services including but not limited to:
  - Blood pressure screenings and follow up
  - Medication adherence support
  - Assessment of safety and efficacy of their current hypertension medication regimen
  - Assistance with acquisition and education about a home blood pressure monitor
  - Care coordination with healthcare team member
  - Lifestyle modification education



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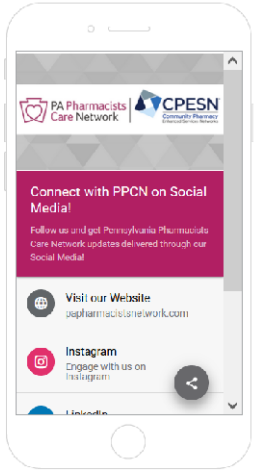

Citations

1. Gaskins RE. “Innovating Medicaid: the North Carolina Experience.” North Carolina Medical Journal. January-February 2017;78(1): 20-24.
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Stephanie McGrath, Executive Director
smcgrath@papharmacists.com
Kelsey Hake, Director of Engagement
khake@papharmaci

papharmacistsnetwork.com

YMCA HHA-BPSM Program

Amy Jacobs

Associate Executive Director, Harrisburg Area YMCA Center for Healthy Living

HARRISBURG AREA YMCA CENTER FOR HEALTHY LIVING

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

AGENDA FOR PRESENTATION

- The Center For Healthy Living
- Blood Pressure Self-Monitoring Program at the YMCA
  - -What is the program?
  - -Program overview
  - -Who qualifies?
  - -How to enroll
- Additional Programs offered at the YMCA Center for Healthy Living

Presented by Amy Jacobs, Associate Executive Director, YMCA Center for Healthy Living

THE YMCA CENTER FOR HEALTHY LIVING

- Located in Harrisburg, PA. Established in 2016
- Facilitates programs in Central Pennsylvania area and beyond
- Vision of the Center is to provide evidence based programs within Pennsylvania communities to help educate individuals on healthy habits in order to prevent chronic health conditions

BLOOD PRESSURE SELF-MONITORING PROGRAM

WHAT IS THE BLOOD PRESSURE SELF-MONITORING PROGRAM?

- Evidence-based program offered to those living with high blood pressure since 2005
- Helps adults with hypertension lower and manage their blood pressure
- Participants will receive support from trained Healthy-Heart Ambassadors for the duration of the four-month program

WHO QUALIFIES FOR BLOOD PRESSURE SELF-MONITORING PROGRAM

- Program is open to ALL community members diagnosed with high blood pressure
- Ages 18 years or older
- NO cost for participant
- Membership included for the duration of the program

BLOOD-PRESSURE SELF-MONITORING PROGRAM OVERVIEW

3-month program with two personalized consultations per month

Daytime and evening classes are available

Participants will receive:

- Blood Pressure Cuff
- Monthly nutrient seminars
- Cooking classes and grocery tours
- 3-month YMCA Adult membership

Facilitated by YMCA-certified instructors, Healthy Heart Ambassadors

HOW TO ENROLL IN BLOOD PRESSURE SELF- MONITORING PROGRAM?

- YMCA Staff receives a referral from a health care provider OR the individual reaches out to our intake specialist via phone or email
- Requires a diagnosis of high blood pressure

ADDITIONAL PROGRAMS AT THE YMCA CENTER FOR HEALTHY LIVING

YMCA's Diabetes Prevention Program
Preventing or reducing one's risk of developing Type 2 Diabetes.

LIVESTRONG® at the YMCA
Helps cancer survivors reclaim their health and well-being following a cancer diagnosis.

YMCA's Healthy Weight and Your Child
Providing a safe, fun and active environment for children and families to explore proven methods to living a healthier lifestyle.

Freedom From Smoking®
Tobacco Cessation programs for children and adults.

YMCA's Weight Loss Program
Helping adults seeking a healthier lifestyle.

Nutrition Counseling
One-on-one or group-based nutrition advice from our Registered Dietitian

Enhance® Fitness
Falls prevention, arthritis, beginner low impact physical activity.

FOR MORE INFORMATION

REACH OUT TO THE

YMCA CENTER FOR HEALTHY LIVING AT:

717-232-2027

HEALTHY.LIVING@YMCAHARRISBURG.ORG

THANK YOU!

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Roundtable Discussion

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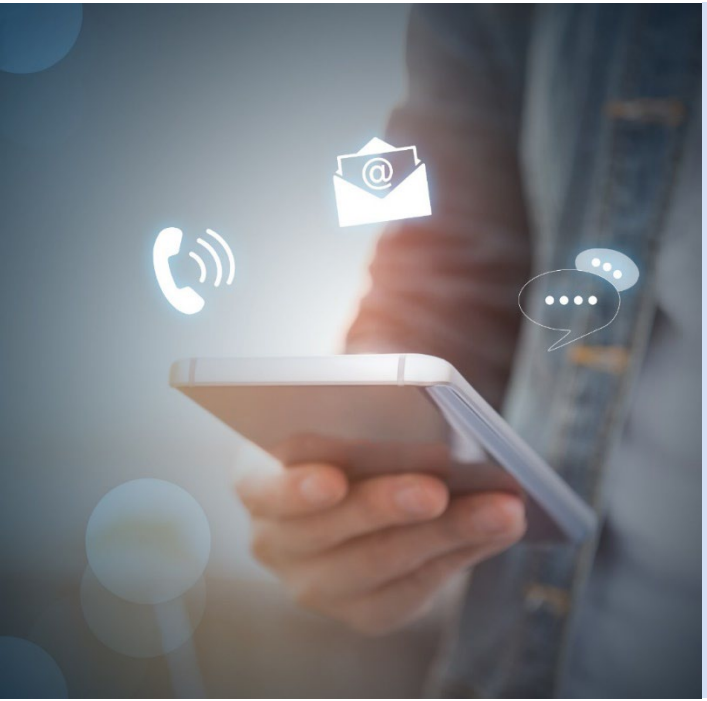

Joseph Pinto, Jr., CHITP, CMAP

Email: jpinto@qualityinsights.org

Phone: 1-800-642-8686, Ext. 7817

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THANK YOU!

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