# Washington Emergency Cardiac and Stroke System
# Summary of Report to the
# U.S. Centers for Disease Control and Prevention

## Pursuant to Second Substitute House Bill 2396

**December 2012**


Publication Number 346-051

For more information or additional copies of this report contact:

Office of Community Health Systems
Health Systems Quality Assurance Division
(360) 236-2869

Heart, Stroke and Diabetes Program
Prevention and Community Health Division
(360) 236-3799

Mary C. Selecky
Secretary of Health

| Page | Contents |
|---|---|

# Executive Summary

In 2010, the Washington State Legislature passed Second Substitute House Bill 2396 (2SHB 2396) to establish a coordinated statewide system of emergency care for heart attack and stroke patients. The U.S. Centers for Disease Control and Prevention (CDC) funded this work. The CDC requires the Department of Health to report its progress on developing the system.

Section 4 of the bill, now RCW 70.168.160, requires the department to share its CDC report on emergency cardiac and stroke care with the legislature. The report is included in Appendix A. Pages 30-36 address emergency cardiac and stroke care.

Working in close consultation with a broad range of cardiac and stroke care providers around the state, the department established the emergency cardiac and stroke system. To date, most hospitals in the state are ready and able to provide evidence-based emergency cardiac and stroke care. Emergency medical services (EMS) responders have procedures in place to get heart attack and stroke patients to the right hospital for the right treatment as quickly as possible. Care providers participate in data systems that monitor and evaluate outcomes and system performance.

## Background and Report Summary

Heart disease and stroke together account for more than a third of all deaths, surpassing all other causes. Many who survive a heart attack or stroke often have significant disabilities and need long-term care. One of the most important factors to address is that too much time passes between the onset of symptoms and treatment. A group of cardiac, stroke and emergency medical services experts were brought together to design a coordinated, system's approach to caring for heart attack and stroke patients. Washington's emergency cardiac and stroke system has begun to make changes so more people will survive stroke and heart attack with less disability. The goal of the system is to get the right patient to the right hospital, for the right treatment, in the right amount of time.

The U.S Centers for Disease Control and Prevention (CDC) funded development and implementation of the Emergency Cardiac and Stroke Plan. The Department of Health reports progress to the CDC quarterly. All requirements of the grant are being met and important accomplishments are being made. The grant support to implement the emergency cardiac and stroke system ends June 30, 2013. This report to the legislature presents a summary of detailed quarterly reports.

The long term objective of this project is to, "establish a statewide, coordinated cardiac and stroke emergency response system." This system is patterned after Washington's successful and highly regarded trauma care system. A system of emergency care must consider resources from both pre-hospital and hospital health care. This approach promotes getting the right patient to the right hospital, for the right treatment, in the right amount of time. Accomplishments outlined in this summary are the product of many discussions and decisions among stakeholders. The department brought together physicians, nurses, paramedics, emergency medical technicians (EMTs), and other providers directly involved in the care of heart attack and stroke patients.

Major accomplishments supporting the long term objective are described below. These are divided between tasks accomplished in pre-hospital settings like emergency medical services (EMS) and hospital settings. Data and quality improvement activities are included.

**Pre-hospital EMS Activities**

EMS responders are often the patient's first contact with the health care system. The goal of pre-hospital emergency cardiac and stroke care is to get the patient to the right hospital as quickly as possible. The pre-hospital accomplishments include developing:

- Evidence-based education for EMS responders on symptom recognition, and care of heart attack and stroke patients.
- Patient treatment protocols guiding care that is provided outside of hospital settings.

- A destination triage tool to guide EMS responders to hospitals best prepared to care for the heart attack or stroke patient.
- Procedures guiding treatment and transport decisions for EMS responders in each county. The destination triage tool frames a more specific process for counties based on unique resources and capabilities within the county.

**Hospital Activities**

The goal of emergency heart attack and stroke care in hospitals is to reduce the time it takes to re-establish blood flow to the heart or brain. Hospital emergency care accomplishments include:

- A system is in place to categorize hospitals capable of providing care to heart attack and stroke patients. Hospitals determine the most appropriate level of categorization based on individual resources and capabilities of the facility. Most (86 of 94) hospitals in the state can provide some level of emergency cardiac care, emergency stroke care, or both. A list of the categorized hospitals is posted on the Department of Health website (http://www.doh.wa.gov/Portals/1/Documents/Pubs/345299.pdf).
- Hospitals categorized to care for heart attack patients: 86.
    - Level I centers, the most comprehensive care: 32.
    - Level II centers: 54.
- Hospitals categorized to care for stroke patients: 86.
    - Level I centers, the most comprehensive care: nine.
    - Level II centers: 31.
    - Level III centers: 46.
- Access to hospital resources that can treat heart attack patients is improved compared to 2007 (see Chart A).
- Access to hospital resources that can treat stroke patients is improved compared to 2007 (see Chart B).

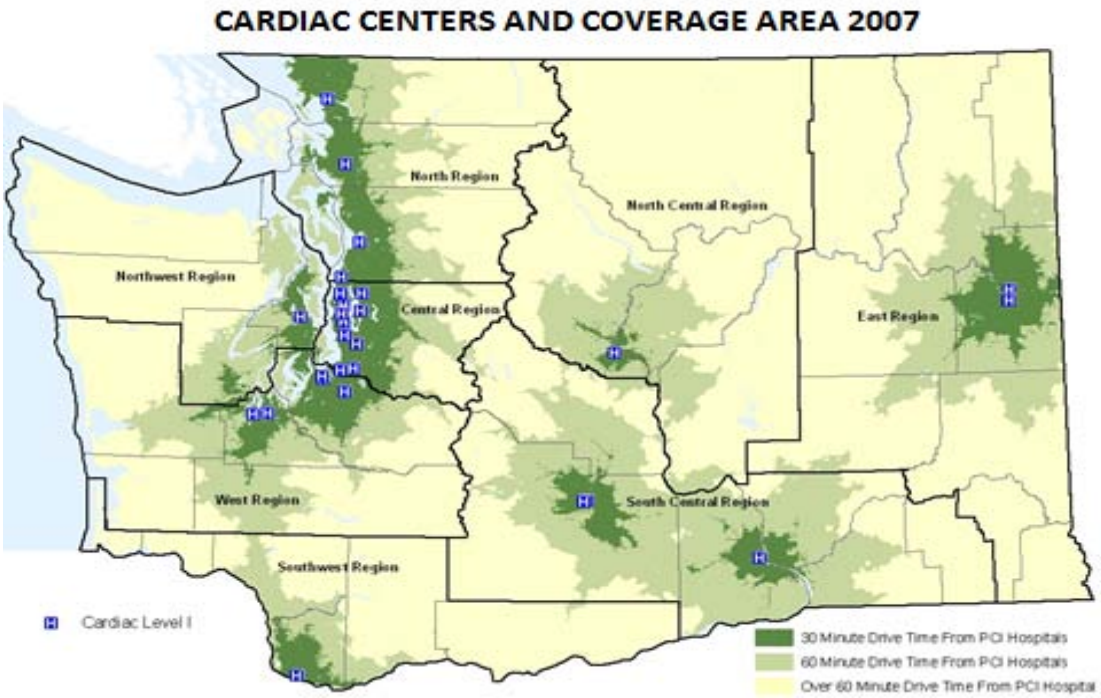
**Quality Improvement and Data Collection Activities**

A coordinated system of care must be constantly monitored and evaluated to support continuous quality improvement. Accomplishments in quality improvement and data collection include:

- Hospitals categorized to provide heart attack and stroke care are required to report to a national, state, or local data collection system. In Washington, these data collection systems include:
    - **Get with the Guidelines for Stroke.** More than half of the hospitals categorized to provide stroke care contribute data to this system.
    - **Clinical Outcomes Assessment Program (COAP)** for heart attack patients. There are 31 Level I cardiac hospitals submitting data to this system.
- More than 55 pre-hospital EMS agencies in 25 counties participate in the **Washington Cardiac Arrest Registry for the Enhancement of Survival (WaCARES)**.

    - This system collects data about patients who suffered sudden cardiac arrest. Participation in this system has doubled in the last year.
- Regional EMS and trauma care systems now include heart attack and stroke data in their established quality improvement forums. Membership in these forums now includes health care providers who care for heart attack and stroke patients.

**Chart A**
**Access to Cardiac Centers in Washington State**
**2007 vs. 2011**



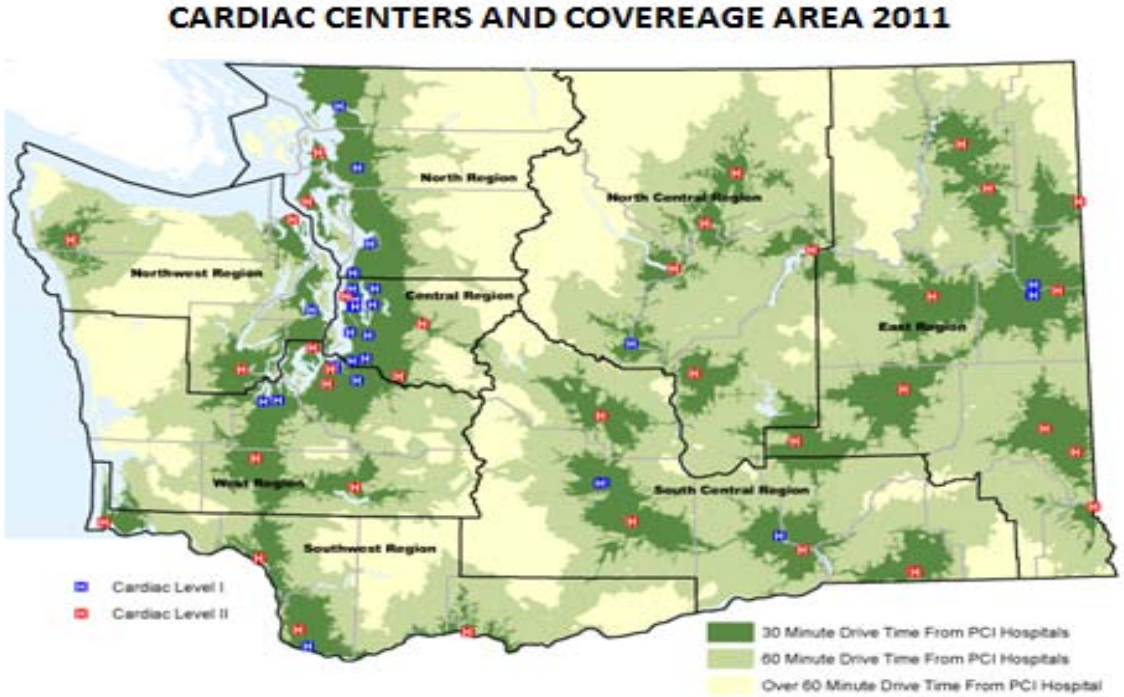
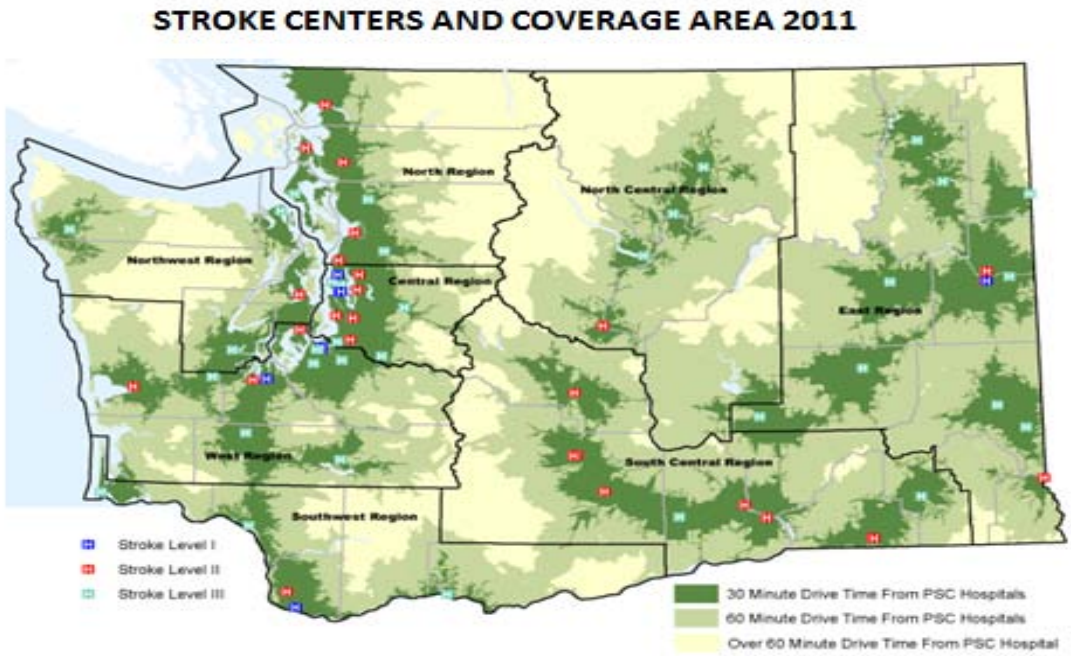



**Chart B**
**Access to Stroke Centers in Washington State**
**2007 vs. 2011**

# Appendix A

## Department of Health Report to the

## U.S. Centers for Disease Control and Prevention

## Washington State Heart Disease and Stroke Prevention Program

# Washington State Department of Health

**Budget Year Progress: 6/30/2011 - 6/29/2012**

**Grant Number: DP000727**

**Program Announcement: DP07-704**

---

# Heart Disease and Stroke Prevention Program

End of Year - Project Narrative

**Date Submitted: September 27, 2012**

# A. Executive Summary of Work Accomplishments

The Washington State Patient-Centered Medical Home Collaborative successfully completed a two year initiative supporting 32 clinic practice teams in redesigning their practices to become Patient Centered Medical Homes (PCMH) to better address risk factors for heart disease and stroke. All teams were asked for data related to: 1) Patient experience; 2) Provider and team satisfaction, 3) Degree to which clinics were able to implement the components of a PCMH, and 4)Process and clinical outcome measures. The overall score for medical home indicators improved over the two year collaborative. Patient experience showed moderate improvement over all, with individual clinics showing more meaningful results. Provider and staff satisfaction showed modest improvement, with room for improvement in some areas. All but one of the clinical measures for diabetes showed improvement. December 2011-June 2012, planning for the next iteration of the QI work took place. The result is the Washington Healthcare Improvement Network (WHIN), a Department of Health initiative designed to work with primary care organizations and the communities in which they reside to 1) Develop and support Patient-Centered Health/Medical Homes; 2) Achieve more effective care transitions and care coordination across healthcare settings and providers; and, 3) Provide intensive care management and coordination services for complex patients with multiple medical/behavioral health conditions and psychosocial barriers. WHIN, in collaboration with local health and community organizations, will provide training and technical assistance to practices interested in becoming patient-centered health/medical homes. This will include training and technical assistance that address high-impact quality clinical preventive services. Support will be focused regionally, and will be tailored to the needs of the community.

Initiatives to address the accurate measurement of and improvement in the management of hypertension continued through Sea Mar Community Health Center's Blood Pressure Quality Improvement Pilot Project, which ended in May 2012. Practice change and clinical outcomes are being analyzed. Preliminary results have been positive. Compared to baseline, across all 11 clinics, there has been a 22% increase in blood pressure control. Materials provided during the pilot were tested and suggestions for improvements have been incorporated. The final version of the "Implementation Tool for Clinic Practice Teams in Improving the Screeening, Prevention and Management of Hypertension", is expected to be available by the end of October 2012.

The statewide coordinated emergency response system to improve emergency response and outcomes for heart attack, stroke, and cardiac arrest is implemented consistent with the state plan objectives, the recommendations in the 2008 report, and the state law passed in 2010. Patients are transported to designated hospitals according to state policy and protocol guidelines, reducing time to treatment and increasing the number of strokes treated with t-PA. Data sources have been identified and mechanisms for

quality improvement developed by leveraging existing resources. We are transitioning maintenance of the system from HDSP to the EMS and Trauma section.
The Healthy Communities Program work targeting specific counties has been aligned and expanded with Washington's Healthy Communities Washington Initiative, funded in 2011 through a statewide Community Transformation Grant (CTG). Receipt of the CTG grant expands work in counties and regions with low capacity and high need to address chronic disease risk factors such as poor nutrition, physical inactivity and tobacco use. We provide technical assistance, consultation and training in policy, systems, and environmental change; assessment of local needs and assets; help build partnerships and develop action plans that address these risk factors. The work of the Washington Healthcare Improvement Network aligns with and supports regions identified by CTG funding and other state reform efforts for Medicaid eligible residents.
A pilot community health worker program providing a core curriculum followed by a Heart Disease and Stroke-specific module was launched, and is now being expanded to the CTG regions. The updated "Energize Your Meetings" procurement guidelines for healthy eating that include lower sodium options to address high blood pressure are being used for healthier procurement for state agencies that provide food in institutional settings. We analyzed the most recent BRFSS, CHARS and Vital Statistics data to update the CVD Surveillance Notebook. These resources will continue to guide program planning, implementation, and evaluation.

# B. Program Information

General and Contact Information:

| | |
|---|---|
| Program Name: | Washington State Department of Health |
| Grant Number: | DP000727 |
| Program Telephone: | 360-236-3792 |
| Program Address: | 111 Israel Road SE, Box 47855<br>Olympia, WA 98501-7855 |

Program Personnel:

Staffing

As of June 2012, the HDSP program was staffed with a manager, systems of care coordinator, and a public health nurse consultant who specializes in quality improvement. The HDSPP also supports program reporting, QI metrics, Healthy Communities Program staff, epidemiology, evaluation, fiscal, communications, and administrative services, like many other chronic disease programs.

Chronic Disease Integration and Collaboration

The HDSPP is housed in the Practice Improvement Section of the Office of Healthy Communities, along with Diabetes; Asthma; Screening and Genetics; the Medical Home Collaborative; and some maternal and child health programs. We continue to integrate our efforts to maximize our resources and impact on preventing and managing chronic conditions across the lifespan. We continue to provide input to the Washington State Plan for Healthy Communities, the coordinated chronic disease plan slated for completion in July 2013. Nearly all of our projects are collaborative, including the WA Patient-Centered Medical Home Collaborative/Washington Healthcare Improvement Network and implementing the Community Transformation Grant. Multiple funding sources and staff are pooled to address common risk factors for several chronic diseases. The Emergency Cardiac and Stroke System work is also a collaborative project, now transitioning to our EMS and Trauma System resources housed in another division.

| Name | Primary Role | Program Time Allocation |
|---|---|---|
| Sarliker, Sara Eve | Program Manager | 50% |
| Nandi, Paj | Program Manager | 100% |

| | | |
|---|---|---|
| Hailu, Asnake | Epidemiologist | 100% |
| Sitaker, Marilyn | Epidemiologist | 30% |
| Chamie, Chara | Other - WA Stroke Forum Coordinator | 100% |
| Ellings, Amy | Other - Nutrition Consultant, HEAL Manager | 1% |
| Holt, Gary | Communication Specialist | 25% |
| Kelley, Kim | Other - systems of care improvement coordinator | 100% |
| Lane, Tim | Other - Program Manager of Nutrition Physical Activity Program | 2% |
| Lynch, Kate | Communication Specialist | 25% |
| McDermot, Dennis | Other - Research Investigator | 20% |
| Mikkelsen, Megan | Evaluator | 50% |
| Norman, Jan | Program Director | 25% |
| Rush, Colette | Other - Quality Improvement Coordinator | 100% |
| Saunders, Rachel | Health Educator | 100% |
| Schmitt, Kathy | Other - EMS Specialist | 5% |
| Shields, Anne | Other - Chronic Disease Health Improvement Director | 30% |
| Thompson, Juliet | Other - Tobacco Cessation Specialist | 1% |

# C. Current Budget Period Progress - June 30, 2011 to June 29, 2012

## Capacity Building Objectives

**Capacity Building Objectives: Develop, maintain, and enhance a diverse and active partnership to plan, implement, and coordinate heart disease and stroke prevention activities within the State.**

**Products:**
- Comparison of CDPU Coalition Characteristics
- NWRSN_Steering Committee Membership List
- Heart Disease and Stroke Prevention Steering Council Interim Report 6-2008
- NWRSN_NetworkNewsletter_October2008
- NWRSN_NetworkNewsletter_November2008
- NWRSN_NetworkNewsletter_December2008
- NWRSN_NetworkNewsletter_Jan2009
- NWRSN_StrokeNetwork_MembershipList
- NWRSN_WeeklyUpdates
- NWRSN_NetworkNewsletterFebruary2009
- NWRSN_NetworkNewsletter_March2009
- NWRSN_Partnership Terms of Understanding
- NWRSN_NetworkNewsletter_AprilMay2009
- NWRSN_Steering Committee Planning Document
- Final project report of Spokane integration pilot
- NWRSN_NetworkNewsletter_JuneJuly2009
- NWRSN_NetworkNewsletter_AugSept2009
- NWRSN_NetworkNewsletter_OctNov2009
- NWRSN_NetworkNewsletter_DecFeb
- NWRSN_NetworkNewsletter_MarchApril
- NWRSN_NetworkNewsletter_SPECIAL EDITION

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Partnerships to sustain heart disease and stroke prevention activities<br>**Status:** Completed<br>**Time frame:** 07/01/2009 - 06/01/2012<br>**Description:** HDSP program will continue to engage with multiple stakeholders and partners invested in improving cardiovascular health, in addition to preventing and managing heart disease and stroke in Washington. We will work with the Emergency Cardiac and Stroke Technical | **11/28/2011** | **Personnel:**<br>- Sarliker, Sara Eve<br>- Chamie, Chara<br>- Ellings, Amy<br>- Holt, Gary<br>- Kelley, Kim<br>- Lynch, Kate<br>- Mikkelsen, Megan<br>- Rush, Colette<br>- Saunders, Rachel<br>- Schmitt, Kathy |

Advisory Committee/American Heart Association to implement recommendations and policies of the ECS report, partner with Stroke Forum members and professionals to enhance stroke systems of care, and integrate our approach to preventing heart disease and stroke through systems, policy and environmental change at the local community level.
The closest partnerships are with the other programs in the Practice Improvement Section of the Office of Healthy Communities. The Diabetes Prevention and Control Program and the HDSP are now housed in the Heart, Stroke and Diabetes Program in the Chronic Disease Unit of the Practice Improvement Section. This will also be accomplished through continued collaboration with multiple DOH/Healthy Communities Office programs including Tobacco Prevention and Control, Healthy Eating/Active Living (HEAL), and DOH's internal Healthy Communities Program, all housed in the Community-Based Prevention Section.

The Community Transformation Grant and Million Hearts have led to new or enhanced partnerships within and outside of the Department of Health. The HDSP Manager, Sara Eve Sarliker, was appointed the lead liaison for the Practice Improvement Section to the Community Transformation Grant team. On Nov. 28, a "Kick-Off" meeting was held with major contractors to be funded through the CTG grant (Comprehensive Health Education Foundation, Washington Association of Community and Migrant Health Centers), the Local Health Jurisdictions that make up the five regional "hubs" through which the CTG work flows on the local level, and DOH program staff from across the Office of Healthy Communities.

**06/11/2012**

HDSP Manager and staff members are core members of the Community Transformation Grant team, meeting weekly for "huddles" with the CTG Cross-Office team between February and June 2012. The internal partners present at these meetings and other coordinated efforts include these programs: Healthy Eating Active Living, Tobacco, Cancer, Healthy Communities, Diabetes and Heart Disease and Stroke Prevention.
Although it has taken some time for the Community Transformation Grant partners to come together, the partnership is now strong and functional, with excellent communications systems established.

**06/25/2012**

- Shields, Anne

**Partners:**

- American Heart Association
- Diabetes Prevention and Control Program
- Emergency Cardiac and Stroke Technical Advisory Committee
- Nutrition and Physical Activity Program
- Office of Emergency Medical Services and Trauma System

**Contractors:**

| | |
|---|---|
| | Beginning in December 2011 and continuing through June 2012, HDSP staff members were intergral to the planning for the next iteration of the Washington State Collaborative. This planning group hs been made up of members of the core Patient Centered Health/Medical Home Program, Diabetes Prevention and Control Program, Children with Special Healthcare Needs, Cancer Control and Asthma, and as an external partner, the Washington Association of Community and Migrant Health Centers. has been meeting to create a transformed structure that allows for regional and statewide learning networks to be convenened and coached by DOH experts. As of June 2012, the group had identified the first region for the work to begin in, Whatcom County, which has formed an Accountable Care Organization, and has asked for the Department of Health's technical expertise and training in Patient Centered Health Home work. |

**Capacity Building Objectives: Develop scientific capacity to define and monitor the cardiovascular disease burden in the State and produce a regularly updated cardiovascular disease burden document.**

**Products:**
- Health of Washington - Stroke
- NWRSN_Website
- County Profiles
- CDPU Comprehensive data for Planning
- NWRSN_TelemedicineExpertPanelSummaryStatement
- NWRSN_Regional stroke burden report
- NWRSN_Regional flight/drive time maps to Primary Stroke Centers
- NWRSN_Regional Needs Assessment Factsheet (EMS)
- NWRSN_Regional Needs Assessment Factsheet (Distance Learning)
- NWRSN_Regional Needs Assessment Factsheet (Telestroke)
- NWRSN_Regional Needs Assessment Factsheet (Rehabilitation)
- NWRSN_Regional Needs Assessment Factsheet (Stroke Policies)
- NWRSN_Regional Needs Assessment Factsheet (Community Groups)
- NWRSN_Regional Needs Assessment Factsheet (Acute Stroke)
- NWRSN_Regional Needs Assessment Factsheet (Executive Summary)
- NWRSN_Regional hospital acute stroke survey
- Key Findings of the Caregiver Risk Analysis
- National Stroke Network Journal Article
- NWRSN_Regional Rural Health Conference Presentation
- Striking Rural-Urban Disparities Observed in Acute Stroke Care Capacity and Services in the Pacific Northwest
- WA State HDSP blood pressure logic models and indicators

- HDSP Burden Report Update Document
- BP products

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Comprehensive heart disease and stroke surveillance data<br>**Status:** In process<br>**Time frame:** 06/01/2006 - 06/01/2013<br>**Description:** Analyze existing heart disease and stroke data sources to inform, guide, and help evaluate the work of HDSPP. Investigate new data sources where possible. Use new and updated data analyses to inform the revision and overall update of the 2004 "Burden of Heart Disease and Stroke in Washington State" to guide program planning and implementation. | **12/31/2011**<br>Continued to monitor burden of heart disease and stroke in WA State using key surveillance resources, including hospitalization, death, and BRFSS data. Included analysis of health disparities among population subgroups (e.g., age, sex, race, Hispanic origin, and socioeconomic status).<br>**06/29/2012**<br>Continue to monitor population health indicators for heart disease and stroke using key surveillance sources including hospitalization, death, and BRFSS data. Analyze data by socio-demographic factors (e.g., age, sex, race, Hispanic origin, income/poverty status and education) and by county/regional levels.<br><br>Collaborate with Epidemiologists in the Surveillance & Evaluation Section in the Office of Healthy Communities to incorporate heart disease and stroke related population indicators into shared data products (e.g. county and regional fact sheets and state plans). Continue to provide assessment data for internal and external requests and products, state proclamations, and statewide performance measure monitoring.<br><br>Submitted proposal to DOH BRFSS to include aspirin use and salt-intake questions on the 2013 BRFSS state survey to collect information on these health behaviors statewide and in priority populations throughout the state (including racial and ethnic minorities, lower so | **Personnel:**<br>- Mikkelsen, Megan<br>- Sarliker, Sara Eve<br>**Partners:**<br>**Contractors:** |

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Analysis and Dissemination of Existing Heart Disease and Stroke Data<br>**Status:** Completed<br>**Time frame:** 07/01/2008 - 06/01/2011<br>**Description:** Analyze the BRFSS, CHARS, and Vital Statistics databases to create the CVD Surveillance Notebook; continue analysis of the Washington Adult Health Survey; | **12/31/2011**<br>Updated chronic disease county profiles. Developed presentation on the burden of heart disease and stroke for annual Emergency Cardiac and Stroke System Conference in Summer 2011. | **Personnel:**<br>- Mikkelsen, Megan<br>- Hailu, Asnake<br>- Holt, Gary<br>**Partners:**<br>- Office of Epidemiology<br>**Contractors:** |

produce data for publication on the HDSPP website, along with Chronic Disease Combined County Profiles for use by the HDSPP program and external partners.

| Activity | Progress | Resources |
|---|---|---|
| **Title:** DHDSP Indicators<br>**Status:** In process<br>**Time frame:** 06/01/2009 - 06/01/2013<br>**Description:** Develop capacity to use the DHDSP indicators to measure and evaluate HDSPP work. Explore data sources for DHDSP indicators and participate in the communities of practice. | **12/31/2011**<br>Continuing to work on populating DHDSP indicators to evaluate HDSP work. Recently added analysis of Medical Home Index.<br>**06/29/2012**<br>Continue to work on incorporating chronic disease indicators into assessment and evaluation activities. Promoting and incorporating use of indicators related to hypertension and cholesterol control in a) statewide Health Information Exchange efforts and b) quality improvement and evaluation activities related to statewide health care reform initiatives (e.g., Patient-centered Health/Medical Home). | **Personnel:**<br>- Mikkelsen, Megan<br>- Kelley, Kim<br>- Nandi, Paj<br>- Rush, Colette<br>- Saunders, Rachel<br>- Sitaker, Marilyn<br>**Partners:**<br>**Contractors:** |

| Activity | Progress | Resources |
|---|---|---|
| **Title:** DHDSP Indicators Pilot Project<br>**Status:** Completed<br>**Time frame:** 06/01/2009 - 06/01/2012<br>**Description:** Pilot the use of select DHDSP indicators with one HDSPP project. | **12/31/2011**<br>Completed analysis of patient-centered medical home measures. Working on incorporating into tracking document.<br>**06/29/2012**<br>Completed Hypertension Indicator Pilot Project using the 2010-2011 Patient-Centered Medical Home Collaborative. Finishing final summary report on indicators selected and results. | **Personnel:**<br>- Mikkelsen, Megan<br>**Partners:**<br>**Contractors:** |

## Capacity Building Objectives: Develop, update, and facilitate implementation of a comprehensive CVH State Plan.

**Products:**
- NWRSN_Regional Strategic Plan
- Office of Healthy Communities Strategic Plan Framework - Draft

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Cardiovascular state plan<br>**Status:** In process | **12/29/2011** | **Personnel:**<br>- Sarliker, Sara Eve<br>- Kelley, Kim |

**Time frame:** 06/01/2011 - 06/01/2013

**Description:** Update and revise the Washington State Action Plan for Heart Disease and Stroke Prevention and Management in concert with the proposed integrated WA State Chronic Disease State Plan.

The comprehensive plan for chronic disease prevention and control within the Office of Healthy Communities at the Department of Health is under development. Sara Eve Sarliker, program manager, meets regularly with Michele Haymond about the shaping of the comprehensive plan to align with HDSP program goals and directions, including Million Hearts.

**12/29/2011**

Coordinated with the Office of Health Communities on the draft Coordinated Chronic Disease Prevention and Health Promotion Program plan (CCDPHP), called the Washington State Plan for Healthy Communities. Draft documents were submitted as part of the 901 supplemental funding in January 2012. A copy of the Office of Health Communities strategic framework for this plan is included in attachments.

**06/15/2012**

Throughout the timeframe, the HDSP Manager has been reviewing and providing feedback on the Office of Healthy Communities Coordinated State Plan to address chronic disease prevention. The direction adopted by the Office of Healthy Communities includes a lifecourse perspective, and the HDSP manager has been reviewing materials to insure that this approach includes appropriate attention to the populations most greatly affected by heart disease and stroke, while maximizing opportunities for intervention early in life and in the prenatal period to prevent the onset of disease and risk factors for disease.

- Rush, Colette
- Shields, Anne

**Partners:**

- American Heart Association
- Asthma Program
- Diabetes Prevention and Control Program
- Emergency Cardiac and Stroke Technical Advisory Committee
- Nutrition and Physical Activity Program

**Contractors:**

# Intervention Objectives

## Priority Area : Control high blood pressure

### Long Term Objective: Increase number of HDSP sponsored initiatives engaging in system changes to control hypertension.

**Objective**
By 06/2013, increase the number of initiatives engaging in system changes to control hypertension from 1 to 4.

**Describe the objective and how it will impact the problem:**
The control of high blood pressure requires system and policy changes at every segment of the health care continuum and in community organizations and worksites that come in contact with individuals seeking to improve BP control or that have the ability to support individuals in improving their BP. The HDSP selects and implements initiatives that support organizations to make sustainable system and policy changes that improve BP control.

**Primary Outcome:** Control high blood pressure

**Secondary Outcome:** Improve quality of care (prevent first and second events; control risk factors and the diseases)

**Status:** In process

**Time frame:** 07/01/2009 - 06/01/2013

**12/20/2011:**

**Objective Met:** No

We have developed partnerships with other state organizations and initiatives that are working to control hypertension in order to expand our reach to more primary care settings. These organizations include the SeaMar CHC's, our state QIO in their CV 10th scope of work and the Washington Patient Centered Collaborative. We have developed a comprehensive training program that can be made available to primary care or used in training practices and individuals.

**Barriers/Issues:** We are progressing nicely with making partnerships and developing training programs to support practices in system changes to control hypertension. I see no barriers at this time.

**06/29/2012:**

**Objective Met:** Currently Ongoing

Our Public Health Nurse Consultant/QI Specialist has developed extensive partnerships to advance this work. The objective is likely to be met by the end of 2013.

**Barriers/Issues:**

### Supporting Objective: Increase # of community orgs engaged in system changes to improve BP control (Indicator: 1.4.2)

| Obiective | Progress | Products |
|---|---|---|
| | | |

**Objective**

By 06/2012, increase the number of number of intiatives from 0 to 1 within the community setting (Influencing the general population).

**Status:** Completed

**Time frame:** 01/01/2010 - 06/01/2012

**Describe the objective and how it will impact the problem:**

Various community organizations can be leveraged to provide support to those they come in contact with to better control their high blood pressure. Systems changes are required to be able to integrate that support into the daily workflow of the organization. HDSP selects and implements initiatives that support organizations in integrating these system changes to support BP control. Related HTN indicator = 1.4.2

**06/15/2012:**

**Objective Met:** Yes

We have concluded our work with King County EMS. Because of budget cuts and staff reductions they were no longer able to provide resources to this project. What we learned through our efforts in support of EMS Fire Stations continues to inform other work we do to support BP control in the community.

**Barriers/Issues:**

| Activity | Progress | Resources |
|---|---|---|
| **Title:** High Blood Pressure Control: Accurate Measurement and Health Messaging<br>**Status:** Completed<br>**Time frame:** 7/1/2010 - 6/1/2012<br>**Description:** Related activities occurred in 08/09 and 09/10. Many people are unaware they have hypertension, so screening is critical and they will need regular blood pressure checks. However when screenings and checks are performed, inaccurate measurement is common. The errors occur when inappropriate equipment or technique is used. People also need to know their numbers and what to do if BP is high. Fire stations can provide BP checks with appropriate health messaging for the communities in which they reside, but need training to ensure that they are using accurate technique, are providing appropriate health messaging and are integrating the work into their daily activities. Kent, WA fire stations are serving as the pilot sites and received training during last fiscal year and the Kent fire district stations are integrating the protocols into their daily workflow. The HDSP QIC will support the stations through evaluation of the integration and QI support as needed. Discussions continue for training entire region at their annual meeting and placing materials/processes on the | **12/20/2011:**<br>Extensive work was accomplished with King County's Emergency Medical Office's training division. This largest county for EMS services in Washington leads the state in EMS protocols. They also manage the EMSonline training program for a great number of the EMS personel in the state. Our work finished but they decided to not place an entire training program on the EMS online but to instead just place a video for accurate measurement. This will have far reaching results in the state once loaded onto their system.<br>**6/15/2012:**<br>We have concluded our work with King County EMS. Due to budget cuts they were not able to continue the work on the project in any capacity at this time. | **Personnel:**<br>- Rush, Colette<br>- Hailu, Asnake<br>**Partners:**<br>**Contractors:** |

EMS Web site for subsequent statewide spread.

## Supporting Objective: Increase # of healthcare orgs engaged in system changes to improve BP control (1.1.1, 1.1.3 etc.)

| Objective | Progress | Products |
|---|---|---|
| **Objective**<br>By 06/2012, increase the number of initiatives from 1 to 2 within the health care setting (Influencing the general population).<br><br>**Describe the objective and how it will impact the problem:**<br>System changes are required in health care settings in order to improve the control of BP. The HDSP will select and implement initiatives that promote and provide support to such settings in making system changes targeting BP control or through systems that impact the control of BP, such as the work of the Patient-Centered Medical Home Collaborative (described under the Improve Quality of Care priority area). Related HTN indicators are 1.1.1, 1.1.3, 1.1.4, 1.1.5, 1.1.6; 1.1.8, 1.1.9 and 1.2.1. | **Status:** Completed<br>**Time frame:** 07/01/2010 - 06/01/2012<br><br>**06/15/2012:**<br>**Objective Met:** Yes<br>We have concluded our work with SeaMar Community Health Centers in providing training, tools and support for their Blood Pressure Quality Improvement Pilot Project which ended May 2012. Practice change and clinical outcomes continue to be evaluated but preliminary results have been positive. For the 11 participating clinics there was a 22% increase in blood pressure control for the population, representing about 1000 patients with a diagnosis of hypertension. This significant improvement may in part be to the population being on the borderline so small improvements may have moved many patients to control. Never the less, practices have made many changes to improve the control of BP and the organization is now developing a plan for sustaining changes and a plan to continue to work on weak areas.<br>**Barriers/Issues:** | |

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Spreading Best Practice for BP Control in the Clinic Setting<br>**Status:** Completed<br>**Time frame:** 7/1/2010 - 6/1/2012<br>**Description:** In May 2009, the DOH concluded our sixth Washington State Collaborative including a hypertension track. The clinics who participated in this track improved care and made significant changes in how they measured and managed BP and hypertension. In order to spread what was | **12/20/2011:**<br>The SeaMar clinics - 11 of their 18 clinics across western washington treating the highest risk patients launched a quality improvement project in March 2011 and continues. The practice teams are using the training materials provided to make system changes to improve the mgt of blood pressure. They have recently changed their EMR's and are having data collection problems which they hope to resolve in the new year. The practice teams have made many changes in the BP measurement protocols, in how they work with the patient such | **Personnel:**<br>- Rush, Colette<br>- Hailu, Asnake<br>- Mikkelsen, Megan<br>**Partners:**<br>**Contractors:** |

| | | |
|---|---|---|
| | learned through the collaborative, four regional trainings will occur along with a toolkit that will include examples of how to integrate what is learned into practice. Evaluation will include a pretest at the training and a 3 -6 mth post survey to identify whether the training and toolkit were effective in promoting clinic changes that are known to improve BP control. | as implementing group visits, in adhering to JNC-7 protocols and in supporting patient self-management. We will review data once received and also ask teams to complete a second survey assessing the practice change. The survey was to be provided quarterly but it was decided that progress would be better realized if performed one year later.<br>**6/15/2012:**<br>Training was provided by the HDSP program staff in collaboration with the UW Hypertension Clinic Medical Director and Staff. Process and Outcomes measures were tracked over time as well as practice behavior change/system changes. Practice change and clinical outcomes continue to be evaluated but preliminary results have been positive. For the 11 participating clinics there was a 22% increase in blood pressure control for the population, representing about 1000 patients with a diagnosis of hypertension. The organization and practices area now developing a plan for sustaining changes to improve BP control. |

## Supporting Objective: Support to Check BP at Worksite (Indicators: 1.3.6; 1.4.2; 1.4.4; 1.11.1)

| Objective | Progress | Products |
|---|---|---|
| **Objective**<br>By 06/2012, increase the number of work sites that enact policies or standard practices that enables people to check their blood pressure at work from 0 to 10 within the work site setting (Influencing the general population). | **Status:** Completed<br>**Time frame:** 07/01/2010 - 06/01/2012 | |

**Describe the objective and how it will impact the problem:**
There are currently no environmental supports or policy-based motivators to encourage employees to check their blood pressure at work. It is estimated that by meeting this objective in at least 10 work sites we will directly impact at least a few hundred and possibly as many as several thousand people (roughly estimated from currently targeted work sites). This activity may also encourage high blood pressure control in settings (especially homes) outside of the worksite. Our intention is to provide businesses, with special outreach to small and medium size companies with low wage earners, the tools and technical assistance to develop and implement effective policies and practices that prevent heart disease and stroke. Smaller companies often lack the resources of larger companies, and low wage earners are targeted because they often experience higher rates of heart disease and stroke and have higher prevalence of risk factors.

**12/01/2011:**

**Objective Met:** Currently Ongoing

Though we have exceeded our initial target for this objective, promotion and support of "How to Check Your Blood Pressure" (simple tools that support that support use of 'home' blood pressure monitors) has been ongoing with business work sites across Washington. No new work site partners (that have requested technical assistance) during this reporting period.

**Barriers/Issues:**

**06/15/2012:**

**Objective Met:** Yes

Update is the same as before with worksites/organizations..as well as health care organizations requesting the tools across the state.

**Barriers/Issues:**

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Promo, training, TA support to work sites for "How to Check Your Blood Pressure"<br>**Status:** Completed<br>**Time frame:** 7/1/2010 - 6/1/2012<br>**Description:** WA HDSP Program has developed and pilot tested materials to support awareness and self-management of high blood pressure in the worksite. “How To Check Your Blood Pressure” has simple directive guidelines for site managers and coordinators on how to establish and maintain facilities and equipment for blood pressure self-monitoring, as well as easy to follow instructions for individuals to use blood pressure monitors. Materials developed and tested include guidelines, instructional tools such as wall posters and an at-hand manual, as well as a sample promotional flyer. HDSPP will promote the WA DOH “How to Check Your Blood Pressure” with Washington-based employers, and provide training and TA to support work sites in their efforts to establish the WA DOH “How to Check Your Blood Pressure”. | **12/1/2011:**<br>Though we have exceeded our initial target for this objective, promotion and support of "How to Check Your Blood Pressure" (simple tools that support that support use of 'home' blood pressure monitors) has been ongoing with business work sites across Washington. No new work site partners (that have requested technical assistance) during this reporting period.<br>**6/5/2012:**<br>HDSP staff worked with Washington Health Care Authority providing technical assistance in development of on-site facilities for the agency's employees whereby people can use HDSP developed support materials (wall posters as well as bp monitor user guides and tear-out blood pressure tracker with motivational messaging) and HCA purchased equipment to check their blood pressure while at work. Also provided technical assistance to support a demonstration and promotion event on "How to Check Your Blood Pressure" (using HDSP developed materials and HCS equipment) to be held in connection with a health fair for agency staff June 20,2012 for approximately 1100 employees. | **Personnel:**<br>- Saunders, Rachel<br>**Partners:**<br>**Contractors:** |

**Status:** Completed

**Time frame:** 7/1/2010 - 6/1/2012

**Description:** WA HDSP Program has developed and pilot tested materials to support awareness and self-management of high blood pressure in the worksite. “How To Check Your Blood Pressure” has simple directive guidelines for site managers and coordinators on how to establish and maintain facilities and equipment for blood pressure self-monitoring, as well as easy to follow instructions for individuals to use blood pressure monitors. Materials developed and tested include guidelines, instructional tools such as wall posters and an at-hand manual, as well as a sample promotional flyer. HDSPP will promote the WA DOH “How to Check Your Blood Pressure” with Washington-based employers, and provide training and TA to support work sites in their efforts to establish the WA DOH “How to Check Your Blood Pressure”.

## Supporting Objective: Support policies and procurement guidelines to reduce sodium intake (1.3.6)

| Objective | Progress | Products |
|---|---|---|
| **Objective**<br>By 06/2014, increase the number of policies or guidelines from 0 to 1 within the work site setting (Influencing the general population). | **Status:** In process<br>**Time frame:** 12/01/2010 - 06/01/2014 | |
| **Describe the objective and how it will impact the problem:**<br>High levels of sodium in the food supply has been linked to high blood pressure. Policy changes that limit sodium intake through procurement and purchasing of foods high in sodium can have an impact on lowering blood pressure and subsequent cardiovascular diseases in the general population. | **09/01/2011:**<br>**Objective Met:** Currently Ongoing<br>Revisions to "Energize Your Meeting" guidelines for meal planning and food procurement have been completed and published with new standards set for reducing sodium content at government sponsored events. Promotion of the new guidelines and publication has begun although focused strategic efforts have been delayed with the intention of having key stakeholder groups weigh-in on responses to use.<br>**Barriers/Issues:** | |

| Activity | Progress | Resources |
|---|---|---|
| | **9/1/2011:** | **Personnel:** |

**Title:** Promote and implement revised Energize Your Meeting procurement guidelines to state agencies

**Status:** In process

**Time frame:** 6/1/2011 - 6/1/2013

**Description:** The Energize Your Meeting procurement guidelines are being updated to include lower sodium guidelines to address high blood pressure in the general population. These guidelines serve as a purchasing and procurement resource for state agencies buying meals and other foods for meetings and events. The goal is to strongly encourage state agencies to adopt and apply these guidelines to procure healthier foods in general and in particular, those lower in sodium or sodium-free.

Revisions to "Energize Your Meeting" guidelines for meal planning and food procurement have been completed and published with new standards set for reducing sodium content at government sponsored events. Promotion of the new guidelines and publication has begun although focused strategic efforts have been delayed with the intention of having key stakeholder groups weigh-in on responses to use.

**6/5/2012:**

DOH recently met with 3 Department of Corrections (DOC) staff to discuss the possibility of partnering to implement healthy food procurement policies. DOC started implementing healthier meal plans a few years ago and is interested in continuing this work in partnership with DOH. Both agencies left this meeting with many ideas on how to improve the health of DOC's offenders while keeping in mind the importance cost and efficiency when implementing a healthy food procurement policy. We will have a follow-up meeting by the end of July.

- Saunders, Rachel
- Ellings, Amy

**Partners:**

- Nutrition and Physical Activity Program

**Contractors:**

## Long Term Objective: Establish and promote local policy, environmental supports for HD & S prevention

**Objective**
By 06/2013, increase the number of Washington communities actively engaged to create policy and environmental supports for prevention of heart disease and stroke from 5 to 10.

**Primary Outcome:** Eliminate Disparities

**Secondary Outcome:** Control high blood pressure

**Status:** In process

**Time frame:** 07/01/2010 - 06/01/2013

**Describe the objective and how it will impact the problem:**
We are working to establish statewide local capacity for the development of policy and environmental supports to reduce risk factors for heart disease and stroke. This capacity does not exist in most WA counties, especially for those with limited resources and lower income. The HDSP Program is working as a part of an integrated effort across disease prevention and health promotion programs in the WA DOH to improve the health and quality of life in local communities by preventing and managing chronic disease (including heart disease and stroke) by empowering local health departments and their communities with the skills to change or create policies, environments, and systems where people live, work, play, and go to school. (Related indicators: 1.4.1, 2.4.1; 1.4.2, 2.4.2; 1.4.4, 2.4.3)

**06/29/2012:**

**Objective Met:** Currently Ongoing

The local policy work continues, but at a different pace than previously due to the work of the Community Transformation Grant. Policy reporting systems have been reorganized to fit CTG needs. Ultimately, work to improve environmental and system supports for HD & S prevention will be enhanced by aligning with CTG and supported by the overall Million Hearts Campaign, but in the short term, tracking these changes is more difficult.

**Barriers/Issues:** Changes to the internal structure in the Office of Healthy Communities have meant that the systems for tracking local supports for HD & S prevention have changed. CTG has been a driving force that ultimately will enhance this work, but has been disruptive in the short term.

## Supporting Objective: Healthy Communities project (Indicators: 1.4.1, 2.4.1; 1.4.2, 2.4.2; 1.4.4, 2.4.3)

| Objective | Progress | Products |
|---|---|---|
| **Objective**<br>By 06/2013, increase the number of county health departments taking part in HDSPP-sponsored capacity or implementation efforts to develop local policy and environmental supports for heart disease and stroke from 5 to 10 within the community, health care, school and work site settings (Influencing the priority population). | **Status:** In process<br>**Time frame:** 07/01/2010 - 06/01/2013 | - CTG Hubs Update report<br>- Department of Health and Public Health Prevention Fund: Community Tranformation Grant<br>- Healthy Communities Policy Report Form<br>- Reports on Healthy Communities Capacity Building |

**Describe the objective and how it will impact the problem:**
We are working to establish statewide local capacity, which currently does not exist in most counties, for the development of policy and environmental supports to reduce risk factors for heart disease and stroke. The HDSP Program is working as a part of an integrated effort across disease prevention and health promotion programs in the WA DOH to improve the health and quality of life in local communities by preventing and managing chronic disease (including heart disease and stroke) by changing policies, environments, and systems where people live, work, play, and go to school. HDSP will provide training, coaching, and providing technical support to local public health agencies to build their capacity to find out the needs of the community, pull together partners, develop local solutions, identify funding and resources to support local solutions, and help their communities adopt local solutions.
This work potentially impacts approximately 6,767,900 residents with state level work and minimally impacts approximately 6,000,000 with regional and local level work.

**06/05/2012:**

**Objective Met:** Currently Ongoing

we have met our current goal for this objective but continue this work.

**Barriers/Issues:**

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Training and TA for Local Capacity, Implementation for HD & S Prevention<br>**Status:** In process<br>**Time frame:** 7/1/2010 - 12/1/2012<br>**Description:** Provide technical assistance, consultation and training to select local health jurisdictions to address common risk factors of poor nutrition, physical inactivity and tobacco use that lead to chronic diseases, including heart disease and stroke, through environmental, systems and policy change. Support these communities to undergo community needs assessment and capacity building to assess their readiness to change, build sustainable partnerships and tangible action plans to address these risk factors in a cohesive, integrated way. | **10/1/2011:**<br>WA Community Transformation Grant funds received to support a regional hub model approach to developing and maintaining<br>**12/1/2011:**<br>During the past six months, seven WA county health departments have been engaged in Healthy Communities training and plan development for local work. Counties include: Lincoln, Wahkiakum, Cowlitz, Grant, Lewis, Yakima, and NE Tri (a multiple county consortium). During this time the Washington program has provided local health departments and their community partners with FTE support funds, skill-building training opportunities and technical assistance. The five county health departments that are now in their second year of funding are working with community partners to put into place policies and environmental changes that prevent HD&S and other chronic diseases. They are also working on ways to sustain these efforts, mostly through grant opportunities. State support for these five counties end 12/31/11.<br>Note: Extreme state and federal cuts to primary funding programs (Tobacco and Block grants primarily) have continued to impact the financial stability of Healthy Communities work. | **Personnel:**<br>- Saunders, Rachel<br>- Lane, Tim<br>- Nandi, Paj<br>- Sitaker, Marilyn<br>**Partners:**<br>- Asthma Program<br>- Diabetes Prevention and Control Program<br>- Nutrition and Physical Activity Program<br>**Contractors:** |

| | | |
|---|---|---|
| **Time frame:** 7/1/2010 - 12/1/2012<br>**Description:** Provide technical assistance, consultation and training to select local health jurisdictions to address common risk factors of poor nutrition, physical inactivity and tobacco use that lead to chronic diseases, including heart disease and stroke, through environmental, systems and policy change. Support these communities to undergo community needs assessment and capacity building to assess their readiness to change, build sustainable partnerships and tangible action plans to address these risk factors in a cohesive, integrated way. | **6/5/2012:**<br>Healthy Communities Washington training topics include:<br>1. Shaping Policy for Health Domain 1: Define and Communicate Public Health Problems<br>2. Shaping Policy for Health Domain 2: Applying Policy Analysis Techniques to Public Health Problems<br>3. Shaping Policy for Health Domain 3: Influencing Change Through Advocacy<br>4. Competitive Grant Writing<br>5. Developing Partnerships for Public Health<br><br>Since March, we have provided a total of 11 workshops and trained 211 public health staff, tribal representatives, and community partners. More trainings will be provided through July 2012. | |
| **Activity** | **Progress** | **Resources** |
| **Title:** Healthy Communities: Community Transformation Grant<br>**Status:** In process<br>**Time frame:** 10/1/2011 - 9/1/2014<br>**Description:** Build capacity at regional, local, and state level to change poor health outcomes and address health disparities through upstream strategies that effect changes in policy, environments, programming, and infrastructure. Includes support for regional and local FTE, training and TA, as well as guidance re development of regional structure for administration and formation of regional coalitions, as well as action plan prioritization.<br>The grants address four strategic directions:<br>Tobacco-free living,<br>Active living and healthy eating, High impact evidence-based clinical and other preventive services, specifically prevention and control of high blood pressure, Healthy and safe physical environments. | **12/1/2011:**<br>We have begun to build the following model-based structures to carry out the work of the grant:<br>Leadership Team will support statewide changes in strategic areas through policy, environmental, programmatic and infrastructure changes. Representatives include the governor's office, health care, business, foundations, tribes, organizations, state agencies, local government and housing.<br>Prevention Alliance will drive changes at regional and local levels to boost statewide efforts. They will also work to improve local conditions, especially those within targeted communities.<br>Comprehensive Health Education Foundation (C.H.E.F.) will support the Prevention Alliance work along with representatives from existing coalitions and a member of each regional hub. A member of the Alliance will also serve on the Leadership Team. Under the guidance of the Leadership Team, the Prevention Alliance will:<br>Form and implement a policy agenda<br>Provide a plan for grassroots public education<br>Grow key cro<br>**12/1/2011:**<br>Regional Hubs, formed from the five local health jurisdictions awarded funding, have begun to partner with other local health jurisdictions and regional organzations to: create regional coalitions, select strategies to decrease health disparities in their regions, and begin local activities to address chronic disease risk factors. | **Personnel:**<br>- Saunders, Rachel<br>**Partners:**<br>- Diabetes Prevention and Control Program<br>- Nutrition and Physical Activity Program<br>**Contractors:** |

| | | |
|---|---|---|
| **Description:** | Build capacity at regional, local, and state level to change poor health outcomes and address health disparities through upstream strategies that effect changes in policy, environments, programming, and infrastructure. Includes support for regional and local FTE, training and TA, as well as guidance re development of regional structure for administration and formation of regional coalitions, as well as action plan prioritization.<br>The grants address four strategic directions: Tobacco-free living,<br>Active living and healthy eating, High impact evidence-based clinical and other preventive services, specifically prevention and control of high blood pressure, Healthy and safe physical environments. | Based upon the letters of interest submitted, the following agencies were selected to represent the five regional Healthy Communities Hubs: Grays Harbor County Health Department- "Hub" for Grays Harbor, Lewis, Mason, Pacific and Thurston counties;<br>Clark County Health Department- "Hub" for Clark, Cowlitz, Skamania, and Wahkiakum counties; Whatcom County Health Department- "Hub" for Clallam, Island, Jefferson, Kitsap, San Juan, Skagit, and Whatcom counties; Grant County Health Department-"Hub" for Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Klickitat, Okanogan, Walla Walla, and Yakima counties;<br>Spokane Regional Health District- "Hub" for Adams, A<br>**12/1/2011:**<br>Partnerships: We are building partnerships with existing groups across the state to complete this work. For example,we are working with The Washington Association of Community and Migrant Health Centers (WACMHC) to help meet our goals in the strategic direction of high impact quality clinical preventive services.<br><br>Training: We have developed a plan and schedule to provide regional training statewide for local public health agencies and partner organizations.<br><br>See attached website to view: Latest Progress Update (PDF, 85KB), as well as resources including a map of Regional Hubs by county (PDF, 1.3MB), and a map showing the distribution of public housing and safety net clinics (PDF, 1.4MB) in relation to poverty by ZIP code in the 11 counties targeted for the grant.<br>**6/5/2012:**<br>Hubs have begun work towards convening regional coalitions that includes diverse, multi-sector representation from each county in the region, and that have the capacity to oversee the strategic direction of the project activities and be responsible for ensuring the adoption of policy, environmental, programmatic and infrastructure changes related to area-wide strategic directions. Regional Coalitions include representatives from priority counties, as well as local tribes, YMCA's, housing authorities, and organizations within the region whose programs and policies align with local culture and who are effective in addressing health issues of greatest importance. |

| | |
|---|---|
| | Such organizations include but are not limited to transportation, health, environment, labor, education, and planning.<br><br>Hubs have each identified one regional coalition representative for the statewide Prevention Alliance.<br><br>Hubs have developed plans to engage community members who reside in the region to participate in regio |

## Supporting Objective: Statewide spread of evidence-based self-management programs (Indicators: 1.4.2, 2.4.2; 1.4.4, 2.4.3)

| Objective | Progress | Products |
|---|---|---|
| **Objective**<br>By 06/2012, increase the number of HDSPP supported efforts to ensure the statewide spread and reach of evidence-based programs for self-management from 0 to 1 within the community setting (Influencing the priority population).<br><br>**Describe the objective and how it will impact the problem:**<br>Evidence-based practices, including Stanford's Chronic Disease Self-Management are proven, cost-effective interventions for improving chronic health care outcomes and reducing costs. Among the top ten reasons for medical clinic visits is hypertension, high cholesterol, diabetes. In WA Native American communities, 21.9% of visits were related to cardiovascular disease. | **Status:** Completed<br><br>**Time frame:** 07/01/2010 - 06/01/2012<br><br>**12/01/2011:**<br><br>**Objective Met:** Currently Ongoing<br>Reach to date:1724 workshop attendees, with 1307 of these completing 4 or more sessions (total completer rate 76%). See attached map and progress reports for local spread and further reach specifics for supported ARRA efforts. Of special note: we leveraged funds from the Older Americans Act Title 3B to support five new Area Agencies on Aging sites in offering evidenced-based chronic disease self management programs. The addition of these AAAs means that Washington has almost complete geographic coverage with regards to workshop providers of CDSMP. Sea Mar clinics (serving low income, latino, and russian speakers) plan to adopt CDSMP and spread across WA. All providers are currently working with state and local governments, corporations and private foundations, loal and state health plans, and other public and private entities to create strategies for sustaining programs beyond current grant funding. All are reaching broad populations and delivering to diverse workshop audiences.<br>**Barriers/Issues:**<br><br>**06/29/2012:**<br><br>**Objective Met:** Yes<br>Due to HDSPP supported efforts, statewide spread and | - ARRA AoA CDSMP Progress Report<br>- descriptive map of CDSMP coverage across WA state |

| | | |
|---|---|---|
| | reach of evidence-based programs for self-management was greatly enhanced during this timeframe. The target of 870 self-management education completers was nearly doubled, with 1608 members of the target audience completing a self-management course within the 3 year timeframe.<br>**Barriers/Issues:** | |
| **Activity** | **Progress** | **Resources** |
| **Title:** Training, TA, and consultation for spread of evidence-based programming<br>**Status:** Completed<br>**Time frame:** 7/1/2010 - 6/1/2012<br>**Description:** Partner and collaborate with DSHS and Diabetes to augment their efforts to spread Chronic Disease Self Management Program (through the American Recovery and Reinvestment Act funding) in select Washington communities by providing training, technical assistance and consultation as needed. | **12/1/2011:**<br>Reach to date:1724 workshop attendees, with 1307 of these completing 4 or more sessions (total completer rate 76%). See attached map and progress reports for local spread and further reach specifics for supported ARRA efforts.<br><br>Of special note: we leveraged funds from the Older Americans Act Title 3B to support five new Area Agencies on Aging sites in offering evidenced-based chronic disease self management programs. The addition of these AAAs means that Washington has almost complete geographic coverage with regards to workshop providers of CDSMP. Sea Mar clinics (serving low income, latino, and russian speakers) plan to adopt CDSMP and spread across WA.<br>All providers are currently working with state and local governments, corporations and private foundations, loal and state health plans, and other public and private entities to create strategies for sustaining programs beyond current grant funding. All are reaching broad populations and delivering to diverse workshop audiences.<br>**6/29/2012:**<br>The ARRA grant that supported CDSMP and Tomando within 4 Area Agencies on Aging, ended on March 30, 2012, while some locations continued providing services on a no-cost extention.<br>The total number of attendees of one or more CDSMP/Tomando Control de Su Salud was 2142, nearly 1,000 more than the inital target of 1,200, and the number of completers -- who attended at least 4 of 6 sessions -- was 1,608, nearly twice the target for the grant period, which was 870.<br>HDSPP supported the grant, in partnership with DSHS/Aging and Disability Services Administration, by participating in:<br>• Quarterly meeting between state partners, ARRA funded AAA partners and Older American Act funded AAA partners to discuss CDSMP activities and plans | **Personnel:**<br>- Saunders, Rachel<br>**Partners:**<br>**Contractors:** |

| | |
|---|---|
| | • Monthly meetings between state partners. Additional meeting held to discuss how to involve Community Transformation Grant recipients and CDSMP partners in select counties<br>• Regional states quarterly conference call between CDSMP program managers in Idaho, Al |

## Supporting Objective: Evidence-based policy, systems change (Indicators 1.4.1,2.4.1; 1.4.2, 2.4.2; 1.4.4, 2.4.3)

| Objective | Progress | Products |
|---|---|---|
| **Objective**<br>By 06/2012, increase the number of Washington health and aging systems or health plans engaged in state-level conversations about reimbursement and active support for CDSMPs through referrals from 1 to 2 (Influencing the general population). | **Status:** Completed<br>**Time frame:** 07/01/2010 - 06/01/2012 | |
| **Describe the objective and how it will impact the problem:**<br>HDSP will actively partner with WA Dept of Social and Health Services to create reimbursement and referral changes to provide Chronic Disease Self Management Program (CDSMP) support to seniors with chronic conditions, including heart disease and stroke. | **12/01/2011:**<br>**Objective Met:** Currently Ongoing<br>State level conversations are ongoing but no new outcomes for this work for this reporting period. Factors inherent to current political climate have stalled this work. See progress reports for CDSMP spread work for work details related to this effort.<br>**Barriers/Issues:**<br>**06/29/2012:**<br>**Objective Met:** Yes<br>Currently, Group Health Cooperative does offer support for CDSMP within it's integrated staffing model. Another large plan in the state, the predominant plan state employees, higher education and others, is Uniform Medical Plan. This plan has actively engaged in discussions about offering CDSMP as a covered benefit.<br>**Barriers/Issues:** Regence, the third party administrator for Uniform Medical Plan, cites challenges in accepting billing from non-medical (community-based) providers. | |

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Evidence-based practices: policy, systems change for sustainability<br>**Status:** Completed<br>**Time frame:** 7/1/2010 - 7/1/2012<br>**Description:** Reimbursement: Currently, the Medicaid Waiver is in effect offering CDSMP reimbursement to eligible | **12/1/2011:**<br>State level conversations are ongoing but no new outcomes for this work for this reporting period. See progress reports for CDSMP spread work for work details.<br>**4/27/2012:**<br>Meetings have been ongoing with two entities committed to working toward reimbursment for chronic disease | **Personnel:**<br>- Saunders, Rachel<br>**Partners:**<br>- Diabetes Prevention and Control Program<br>**Contractors:** |

members. A statewide advisory group will provide direction for public and private reimbursement structures for CDSMP modeled after the Medicaid Waiver and the Medicare Advantage Plan.
Referrals: Washington will use a bottom up, top down approach in building referral system. At the local level, contracted partners will form relationships with individual practices and provider groups to promote and refer patients directly to area workshops. At the State level, we will integrate CDSMP referrals into existing systems that are routinely used by primary care providers to obtain services for seniors with chronic conditions.

self-management. Scott Pritchard of the Washington State Health Care Authority's Public Employee Benefits Program, and Dave Hughes of the Physicans of Southwest Washington Independent Physicians Association have been meeting with the HDSP Manager, Sara Eve Sarliker, to discuss mechanisms to support CDSMP reimbursement. The key barrier to reimbursement has been identified as the lack of an entity that can appropriately bill and receive payment for these community-based services provided outside of a medical provider's office.
Group Health Cooperative, the second largest plan that public employees and higher education employees are subscribed to in the state, currently offers chronic disease self-management as part of their integrated staff model. The largest plan containing state employees, higher education employees and their beneficiaries is Uniform Health Plan, which is administ

**6/8/2012:**
Several partners support pursuing reimbursement in addition to HDSP -- these include the Diabetes Network Leadership Team, Aging and Disability Services Administration of the state's Department of Social and Health Services, as well as the many providers of the Chronic Disease Self-Management Program in the state.
The HDSP Manager serves on the state's advisory committee for CDSMP, and participated in writing a grant to the Administration on Aging for continuation of the work begun under the ARRA Grant. The grant recipients were announced in September, and Washington is one of the states to receive this funding.

## Long Term Objective: Create state level policy, environmental supports for CVD prevention.

**Objective**
By 12/2012, increase the number of state level policies and environmental supports for heart disease and stroke to impact workforce development from 0 to 1.

**Primary Outcome:** Eliminate Disparities

**Secondary Outcome:** Control high blood pressure

**Status:** In process

**Time frame:** 07/01/2010 - 12/01/2012

**Describe the objective and how it will impact the problem:**
This kind of work is most effectively accomplished as a unified force of multiple parties or groups with shared interests and common, prioritized agendas. State level work as an integrated, inclusive group of priorities is the focus of current Office work group and includes HDSPP staff. HDSPP priorities and high level objectives are also shared by these work groups.

**06/29/2012:**

**Objective Met:** Currently Ongoing

We are refocusing our worksite efforts and will be better equipped to report on the objective later in 2012.

**Barriers/Issues:**

## Supporting Objective: Increase state level capacity to address healthy equity issues

| Objective | Progress | Products |
|---|---|---|

**Objective**
By 12/2012, increase the number of Washington State Department of Health Employee trainings focused on issues of health equity offered as standards from 0 to 1 within the work site setting (Influencing the general population).

**Status:** In process

**Time frame:** 07/01/2010 - 12/01/2012

**Describe the objective and how it will impact the problem:**
The Office of Community Wellness and Prevention's (CWP) Health Equity team, whose intention is to address health equity within the WA DOH and in the communities that we serve, has skill building and training as its key focus. This type of work has not occurred before at WA DOH. HDSPP staff serve on the team. A health equity training series has been proposed for agency managers/supervisors, CWP staff, and the Health Equity Team, and has been accepted by the CWP Management Team. The Health Equity Team will become the trainers and technical advisors to the office managers and staff related to health equity work.

**12/01/2011:**

**Objective Met:** Currently Ongoing

During the past six months the Office of Healthy Communities Health Equity (HE)Team, with HDSPP staff as lead, has developed a (draft) process tool to support Office staff in a thoughtful and meaningful way of working that ensures issues that impact health equity are addressed.
Plans for testing this tool are underway.
The HE Team has also (with HDSPP staff support) developed a staff survey to be conducted in January 2012 that inquires into organizational readiness as well as staff capacity re HE. This work minimally impacts 200 people, and potentially impacts all populations with health disparities.

**Barriers/Issues:**

**06/05/2012:**

**Objective Met:** Currently Ongoing

On March 13, 2012, Health Equity Team leadership made a presentation to the DOH Senior Management Team regarding a representation on the Governor's Interagency Council on Health Disparities. Both presentations went well and the Equity Impact Review (EIR) tool was discussed.
This presentation was made again on April 9th since half of SMT was not in attendance on first date.
The team (including HDSP staff) have submitted an abstract to Society of Public Health Education (SOPHE) to present

our EIR tool and curriculum at the annual conference in October.
We had an abstract accepted to the WA School Health Conference in May. The presentation will focus on education as a determinant of health and the importance of public health staff working with educational professionals.
Team lead will meet with each unit to present the staff survey results. staff need to work with their supervisor to insure any HE training will not interfere with job responsibilities and the specific topic aligns with staff job description.
Revision of Team Action plan: volunteers will lead efforts. Each group will update project, establish a time line and identify needed resources. The projects are: staff training; communications planning; staff survey; and EIR tool training.
**Barriers/Issues:**

**06/05/2012:**

**Objective Met:** Currently Ongoing

TESTING of EQUITY IMPACT REVIEW TOOL with Russian speaking community through Immunizations Program special project: We completed the two final focus groups last night in Spokane. All of the groups (Vancouver, Renton and Spokane) went really.
It will be at least a couple of weeks before the notes are translated to English and are able to analyze the responses. But we've done some debriefing with the facilitators and note takers and have a sense of a few key issues. Also, our literature review gave us a range of potential concerns and revealed some influential experiences of recent Russian-speaking immigrants.
At present more demographic research is underway using American Fact Finder and American Community Survey data from OFM and the Census Bureau.
We have to make recommendations to Health Care Authority and the Office of Immunizations by June 20. Currently doing the impact analysis (Stages 3-5) to prepare.
In terms of educational interventions, it looks likely that one recommendation will involve community presentations to new parents, where a health expert speaks in person and provides information and answers questions in Russian (as opposed to—or in addition to—creating printed materials).
**Barriers/Issues:**

| | | |
|---|---|---|
| | **06/05/2012:**<br>**Objective Met:** Currently Ongoing<br>CLAS Standards Language Access Policy work:<br>Recommendations developed bu Health Equity Team (with HDSP staff):<br>1. Complete CLAS standards training Part II. This management training will guide participants to complete their program self assessments for all 14 CLAS standards. The three-hour training is targeted for summer or fall 2012 .<br>2. Following the training, each program will complete the self assessment. Ideally the self assessment will be completed by the team with one member designated as lead.<br>3. The self assessments will be analyzed to identify both areas of compliance with CLAS standards and gaps.<br>4. Following the analysis, the HET will make recommendations to PCH senior leadership on low and no cost recommendations to address gaps and be in compliance with CLAS.<br>**Barriers/Issues:** | |
| **Activity** | **Progress** | **Resources** |
| **Title:** Training and TA to support integration of health equity strategies and principles<br>**Status:** In process<br>**Time frame:** 7/1/2010 - 12/1/2012<br>**Description:** Provide technical assistance and training to support the integration of health equity strategies and principles into our work (for all those working within the office of Community Wellness and Prevention). | **12/1/2011:**<br>During the past six months the Office of Healthy Communities Health Equity (HE)Team, with HDSPP staff as lead, has developed a (draft) process tool to support Office staff in a thoughtful and meaningful way of working that ensures issues that impact health equity are addressed. Plans for testing this tool are underway.<br>The HE Team has also (with HDSPP staff support) developed a staff survey to be conducted in January 2012 that inquires into organizational readiness as well as staff capacity re HE. This work minimally impacts 200 people, and potentially impacts all populations with health disparities. | **Personnel:**<br>- Saunders, Rachel<br>**Partners:**<br>**Contractors:** |

## Supporting Objective: Promote calls and referrals to WA State Quitline for cessation counseling (1.6.3, 1.6.4, 2.6.5)

| Objective | Progress | Products |
|---|---|---|
| **Objective**<br>By 06/2012, increase the number of calls to WA State Quitline to 2000 within the community, health care and work site settings (Influencing the general population). | **Status:** Completed<br>**Time frame:** 06/01/2010 - 06/01/2012 | - Washington State Tobacco Quitline resumes service |

**Describe the objective and how it will impact the problem:**
Tobacco use is clearly linked with increase LDL cholesterol and may have an impact on high blood pressure, subsequently leading to cardiovascular diseases. HDSP will support the WA State Tobacco Prevention and Control Program to continue its State Quitline services for comprehensive cessation counseling. This work is well underway and well-established statewide since 2000. Most calls to quitline are made through provider referalls, statewide media push, or through word of mouth by family and friends.

**08/01/2011:**

**Objective Met:** Currently Ongoing

Statewide support for the Washington quitline has been defunded. While services for Medicaid recipients and some business employees still exists, most residents currently do not have access to quitline service. Promotion continues but no positive outcomes to report for this reporting period.

**Barriers/Issues:**

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Promote WA State Quitline<br>**Status:** Completed<br>**Time frame:** 6/1/2010 - 6/1/2012<br>**Description:** Similar to the Tobacco Prevention and Control Program's ARRA goal, the HDSP will support the program's goal, "The capacity of the Quitline will be increased by approximately 2,090 proactive multiple call units and 571 four week supplies of Nicotine Replacement Therapy (NRT)." | **8/1/2011:**<br>Statewide support for the Washington quitline has been defunded. While services for Medicaid recipients and some business employees still exists, most residents currently do not have access to quitline service. Promotion continues but no positive outcomes to report for this reporting period.<br>**12/31/2011:**<br>The State of Washington has provided a free, statewide telephone based Quit Line since November 2000. Since its inception, the Washington Quit Line (WAQL) has received over 195,000 valid calls (as of December 2011) for assistance in quitting tobacco. The WAQL has provided assistance in the form of screening, initial counseling and advice and support materials. However, as a result of statewide budget cuts in the 2011 legislative session, beginning July 1 fewer services are available from the WAQL. Benefits that were once available statewide are now only available for certain groups and people. There are currently no WAQL services available for people who are uninsured, with Indian Health Services or Veteran's Administration and women who are pregnant.<br><br>In 2010 the WAQL received a total of 20,663 calls and 19,190 calls in 2011; this is 2,921 and 724 calls above the baseline average of 18,466 calls per year. Over the 2 year funding cycle, the Washington TPCP increased the number of ca<br>**6/29/2012:**<br>The Department of Health's Secretary of Health, Mary Selecky, has worked toward restoring state funding for the Quitline for uninsured residents in Washington State. Restoring Quitline funding for the uninsured has also been a priority of Governor Chris Gregoire. As of the close of this time period, however, the Quitline remained unfunded for uninsured residents. | **Personnel:**<br>- Sarliker, Sara Eve<br>- Thompson, Juliet<br>**Partners:**<br>**Contractors:** |

## Long Term Objective: Establish statewide coordinated emergency response system.

**Objective**
By 12/2012, increase the number of coordinated systems of emergency response and treatment for acute cardiac and stroke events from 0 to 1.

**Primary Outcome:** Improve Emergency Response

**Secondary Outcome:** Eliminate Disparities

**Status:** In process

**Time frame:** 07/01/2006 - 12/01/2012

**Describe the objective and how it will impact the problem:**
All Washington residents do not have ready access to evidence-based interventions for acute cardiac and stroke events, primarily thrombolytic therapy (t-PA in particular) and primary percutaneous coronary intervention. A statewide coordinated emergency response system that provides consistent, timely pre-hospital assessment and rapid transport to the nearest hospital capable of treating acute cardiac and stroke events will be developed.

**06/29/2012:**

**Objective Met:** Currently Ongoing

The statewide coordinated emergency response system to improve emergency response and outcomes for heart attack, stroke, and cardiac arrest is implemented consistent with the state plan objectives, the recommendations in the 2008 report, and the state law passed in 2010. Patients are transported to designated hospitals according to state policy and protocol guidelines, reducing time to treatment and increasing the number of strokes treated with t-PA. Data sources have been identified and mechanisms for quality improvement developed by leveraging existing resources. We are transitioning maintenance of the system from HDSP to the EMS and Trauma section. Once all counties have implemented the system (14 more to go), this objective will be met.

**Barriers/Issues:**

## Supporting Objective: Trainings on Emergency Cardiac and Stroke Care

| Objective | Progress | Products |
|---|---|---|
| **Objective**<br>By 12/2012, increase the number of training projects to support implementation of the Emergency Cardiac and Stroke System from 6 to 18 within the health care setting (Influencing the general population). | **Status:** In process<br>**Time frame:** 07/01/2009 - 12/01/2012 | - EMS Training Template<br>- Evaluation of ACC STEMI Summit<br>- How to Use Hypothermia to Improve Care After Resusciation from Cardiac Arrest<br>- WA Stroke Forum: Symposium presentations |

**Describe the objective and how it will impact the problem:**
Surveys and studies show that knowledge of and adherence to evidence-based guidelines for pre-hospital and hospital cardiac and stroke care is not universal, resulting in inconsistent care and outcomes. In an effort to ensure that all Washingtonians have access to evidence-based care and the best chance for optimal outcomes, we will provide or support training for emergency medical services providers, cardiologists, stroke coordinators, and emergency department staff. Training content will include clinical topics and implementation of the Emergency Cardiac and Stroke System. It will be provided through a variety of mediums.

**06/29/2012:**

**Objective Met:** Currently Ongoing

We estimate all 15,000 EMS providers in the state have been trained on the signs and symptoms of stroke, the F.A.S.T. assessment, and the state stroke triage algorithm to get patients to stroke centers. This impacts a minimum of 11,700 people who are hospitalized for stroke in WA. This does not include TIAs.

Two webinars on how to perform therapeutic hypothermia (TH) for resuscitated cardiac arrest patients reached 200 physicians, nurses, and EMS personnel in rural and urban settings across the state. It is estimated that these trainings, along with the requirement that hospitals participating in the Emergency Cardiac and Stroke System (99%) have hypothermia protocols, will make TH available to the majority of resuscitated cardiac arrest patients in the state. The number of people who will benefit from hypothermia is low because cardiac arrest survival rates are low, but they are increasing in Washington.

**Barriers/Issues:**

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Emergency Cardiac and Stroke System Training for EMS<br>**Status:** In process<br>**Time frame:** 7/1/2010 - 12/1/2012<br>**Description:** We will train 15,000 emergency medical services personnel on the new Emergency Cardiac and Stroke System. We will develop and disseminate a training template for Medical Program Directors and EMS agency training coordinators that can be customized to their county or region. The template will include an overview of the Emergency Cardiac and Stroke System, specifics on the new prehospital treatment protocols and triage algorithms for acute coronary syndrome and stroke, and resources for supplemental training. It is estimated that meeting this objective in all 39 counties will impact 15,000 EMS personnel and improve emergency response to ACS and stroke. This could in turn impact 5000 acute coronary syndrome patients and 6000 stroke patients annually. The number of patients is 50% of total hospitalizations for heart attack and stroke, | **12/31/2011:**<br>Six of 39 counties have "gone live" with the Emergency Cardiac and Stroke System. This means that EMS providers in these counties have been trained.<br>**6/29/2012:**<br>24 of 39 counties have "gone live" with the Emergency Cardiac and Stroke System. This means that EMS providers in these counties have had additional training on signs and symptoms of heart attack and stroke, how to activate the ECS System in their county, and how to reduce time to treatment for people experiencing acute coronary syndrome, cardiac arrest, and stroke. | **Personnel:**<br>- Kelley, Kim<br>**Partners:**<br>- American Heart Association<br>- Emergency Cardiac and Stroke Technical Advisory Committee<br>- Office of Emergency Medical Services and Trauma System<br>**Contractors:** |

consistent with the literature estimating 50% of patients use EMS for these conditions.

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Emergency Cardiac and Stroke System Conferences<br>**Status:** In process<br>**Time frame:** 7/1/2011 - 12/1/2012<br>**Description:** Share best practices and lessons learned with hospitals and EMS providers at various regional meetings to effectively implement the ECS system. | **11/30/2011:**<br>We have begun work on a webinar training on therapeutic hypothermia (TH). A physician and two RNs will provide a one hour presentation. We have applied for CME to attract more clinicians. We plan to reach 100 emergency department staff. The impact will be improved functional outcomes for resuscitated cardiac arrest patients who receive TH because of the skills learned by physicians and nurses from this training.<br>**12/31/2011:**<br>We've had some initial discussions about what training is needed or recommended: Suggested topics:<br>• Cardiology variability<br>• QI<br>• Data submission<br>• Prehospital 12 lead interpretation<br>• Hospital triage of ambulatory patients<br>• Regionalization of ACS protocols<br>• t-PA under 60 minutes<br>• 1 day course for new cardiac and stroke coordinators and give through the year.<br>**3/30/2012:**<br>Webinar titled "How to Use Hypothermia to Improve Care After Resuscitation from Cardiac Arrest" presented. 146 nurses, physicians, paramedics and EMTs registered for the webinar from rural and urban communities. CE was provided through the American Heart Association.<br>**5/30/2012:**<br>Planning begun for a Stroke Coordinator Best Practice Forum to be held in September 2012. Planning committee of stroke coordinators convened, Save the date flyer distributed, application for continuing education credits for RNs and Certified Professional Healthcare Quality begun.<br>**6/20/2012:**<br>Webinar titled "How to Use Hypothermia to Improve Care After Resuscitation from Cardiac Arrest" presented. 55 nurses, physicians, paramedics and EMTs registered for the webinar | **Personnel:**<br>- Kelley, Kim<br>- Chamie, Chara<br>- Nandi, Paj<br>- Schmitt, Kathy<br>**Partners:**<br>- American Heart Association<br>- Emergency Cardiac and Stroke Technical Advisory Committee<br>- Office of Emergency Medical Services and Trauma System<br>- Rural Healthcare Quality Network<br>**Contractors:** |

from rural and urban communities. CE was provided through the American Heart Association.

## Supporting Objective: Data System and Quality Improvement

| Objective | Progress | Products |
|---|---|---|
| **Objective**<br>By 06/2012, increase the number of data system designs and quality improvement projects for the Emergency Cardiac and Stroke System from 0 to 2 within the health care setting (Influencing the general population). | **Status:** Completed<br>**Time frame:** 07/01/2009 - 06/01/2012 | - Data System Options<br>- Preliminary Cardiac and Stroke System Data Analyses |
| **Describe the objective and how it will impact the problem:**<br>Continue development of a statewide data system and quality improvement component of the Emergency Cardiac and Stroke System. One of the recommendations from the assessment of emergency cardiac and stroke care in WA was to "Develop a comprehensive data system to demonstrate effectiveness [of the emergency cardiac and stroke system] and improve performance through quality improvement. Data collection should include dispatch, EMS and hospitals, and should maximize and integrate existing data systems to avoid duplicate data entry and analysis." Also, support hospital-based quality collaboratives and participation in registries, facilitate sharing data between hospital and pre-hospital providers, WEMSIS, and regional quality improvement programs. Priority: improve emergency response. Potential indicators we should be able to get some data on the following indicators by 06/2012: 3.2.1, 3.2.2, 3.6.1, 3.7.2, 3.7.3, 3.8.1, 3.8.2, 3.8.3, 3.8.4, 3.8.5, 3.9.1. | **12/13/2011:**<br>**Objective Met:** Currently Ongoing<br>By leveraging existing resources, we now have sources of data for heart attack, stroke, and cardiac arrest. Since over 40 hospitals already use or are in process of enrolling in Get With the Guidelines, we are going to use that for stroke. Over 80% of stroke patients are treated at these hospitals. We will obtain a user account so we can create statewide reports. We would consider applying for Coverdell if it becomes available.<br>For heart attack (STEMI and NSTEMI in the future), we have contracted with a state cardiac QI program that will use the Action Registry to get reports on system performance from onset of symptoms to treatment and outcomes.<br>In parternship with our EMS leaders on cardiac arrest care, we are encouraging EMS and hospitals to use CARES. We'll spend the next year recruiting and supporting EMS and hospitals providers to participate, and use the data and reports to fine tune the ECS System and measure our effectiveness in improving emergency cardiac and stroke care.<br>**Barriers/Issues:**<br>**06/29/2012:**<br>**Objective Met:** Yes<br>We have increased the number of data system designs and quality improvement project from 0 to 3 by leveraging existing resources and working with partners. The 3 data systems are Get With the Guidelines for stroke, ACTION Registry/GWTG for STEMI, and WA CARES for cardiac arrest. For stroke, this objective was implemented in 52 of 85 | |

| | | |
|---|---|---|
| | hospitals in the state, serving 92% (8905) of ischemic stroke patients. STEMI: 15 of 31 hospitals that perform angioplasty for STEMI. We'll have door-to-balloon times for all STEMI patients. See preliminary data analyses in products.<br>For cardiac arrest: Washington CARES began in December of 2010. There are over 2100 cardiac arrest cases entered. Over 55 ALS agencies are participating from 25 of the 39 counties. There are 37 hospitals providing outcome data on these cases.<br>We have more than doubled participation in the last year. Completing this objective will provide data at the local, regional, and state level to monitor heart attack, cardiac arrest, and stroke care, and ECS System performance from onset of symptoms to treatment and outcomes.<br>**Barriers/Issues:** Overwhelming data burden on hospitals and lack of funding for abstraction. Many EMS providers do not have resources to collect and report data. Getting prehospital data to hospital abstractors is an issue. We hope some of this can be addressed in regional QI we have supported and promoted. Beyond this, we do not have the resources to work on these problems since emergency response is no longer a priority for HDSP. | |
| **Activity** | **Progress** | **Resources** |
| **Title:** Regional Emergency Medical Services and Trauma System Quality Forums<br>**Status:** Completed<br>**Time frame:** 10/1/2009 - 12/1/2011<br>**Description:** Work with existing Regional EMS and Trauma System Quality Forums to incorporate performance on cardiac and stroke care in addition to trauma care. | **10/30/2011:**<br>We had a conference call for all the Trauma QI leads in the state to introduce them to the ECS System and the ECS law that provides opportunities to incorporate cardiac and stroke care into their regional QI programs.<br>**12/30/2011:**<br>There are 8 regional QI committees. Most of them have begun to incorporate cardiac and stroke care into their QI activities. These are usually done separate from Trauma QI because the issues and hospital staff are different. We will continue to provide technical assistance to these evolving activities, especially as we begin to have some data they can use to evaluate processes and care. | **Personnel:**<br>- Kelley, Kim<br>- Schmitt, Kathy<br>**Partners:**<br>- Emergency Cardiac and Stroke Technical Advisory Committee<br>- Office of Emergency Medical Services and Trauma System<br>**Contractors:** |
| **Activity** | **Progress** | **Resources** |
| **Title:** Cardiac Data Collection and Quality Improvement<br>**Status:** Completed<br>**Time frame:** 8/1/2010 - 6/1/2012<br>**Description:** Conduct a proof of pilot project with the | **12/20/2011:**<br>Proof of concept project completed to determine if the Clinical Outcomes Assessment Program, a state QI program for hospitals that do angioplasty, could produce reports capturing the recommended system data. The concept was proved with 4 | **Personnel:**<br>- Kelley, Kim<br>- Schmitt, Kathy<br>**Partners:**<br>- Emergency Cardiac and Stroke |

| | | | |
|---|---|---|---|
| | cardiac-focused Clinical Outcomes Assessment Program to use the ACTION Registry-Get With the Guidelines to create a Washington State report showing ECS System performance along the continuum from onset of heart attack to treatment. | hospitals. We will move forward with recruiting all 31 hospitals so we'll have system data on the majority of MI patients that are hospitalized.<br>**6/29/2012:**<br>The contractor (COAP) facilitated enrollment of 15 of 31 cardiac level I centers in the ACC's ACTION Registry and 10 in CathPCI as a first step to enable ongoing evaluation of care and outcomes for cardiac patients across the system. They also created a prototype report, and a subcommittee to guide future development on metrics, report distribution, and local, regional, and state quality improvement. | Technical Advisory Committee<br>**Contractors:**<br>- Clinical Outcomes Assessment Program |
| **Activity** | | **Progress** | **Resources** |
| **Title:** Stroke Data Collection and Quality Improvement<br>**Status:** Completed<br>**Time frame:** 7/1/2011 - 6/1/2012<br>**Description:** Enroll additional hospitals in Get With the Guidelines for Stroke to help us evaluate stroke care and outcomes. DOH will enroll as a superuser to get aggregate statewide results. This will serve as our proxy registry in the absence of Coverdell funding. | | **3/20/2012:**<br>The Department obtained a superuser account with Get With the Guidelines for Stroke to monitor stroke care performance on an aggregated state basis.<br>**6/29/2012:**<br>We supported enrollment of an additional 12 hospitals in Get With the Guidelines for Stroke in partnership with the American Heart Association/American Stroke Association. This brings to the total hospitals participating to 52 of 85 stroke centers, covering 92% of ischemic strokes (estimate based on ischemic stroke hospitalizations in the participating hospitals in 2010). | **Personnel:**<br>- Kelley, Kim<br>**Partners:**<br>- American Heart Association<br>- Emergency Cardiac and Stroke Technical Advisory Committee<br>**Contractors:** |

## Supporting Objective: Voluntary Hospital Categorization Program

| Objective | Progress | Products |
|---|---|---|
| **Objective**<br>By 12/2011, increase the number of emergency cardiac and stroke hospital categorization programs from 0 to 1 within the health care setting (Influencing the general population). | **Status:** Completed<br>**Time frame:** 07/01/2010 - 12/01/2011 | - Cardiac Level I Application<br>- Recruitment Letter to Hospitals<br>- Stroke Level II Application |

**Describe the objective and how it will impact the problem:**
Establish a voluntary hospital categorization program to identify hospitals that meet minimum standards to treat heart attack and stroke. Timely treatment and adherence to guidelines clearly improves outcomes for heart attack and stroke; getting patients to hospitals that provide this will reduce death and disability from heart attack and stroke. Emergency Medical Services will transport patients to participating hospitals based on the state acute coronary syndrome and stroke triage algorithms. It is estimated that meeting this objective in 39 counties will impact 70 of 95 hospitals in the state, and increase access to evidence-based treatment for the estimated 5000 heart attack and 6000 stroke patients that use EMS to get to a hospital.

**07/01/2011:**

**Objective Met:** Yes

This objective was met and reported 6/29/11 but carried over into 2011-2012 due to the end date, I assume. Here is the info from last year: The program is established, and to date, 75 or 83% (reach) of Washington hospitals are participating in the new hospital categorization program. We anticipate near 100% hospital participation by 2012. The impact is increased and faster access to evidence-based care for heart attack and stroke for the approximately 9400 people who have a heart attack and 14,500 people who have a stroke annually, whether they arrive at hospitals by EMS or private transport. We do know that more strokes are being treated with the only clot-busting medication available (see attacments). The impact is likely much greater because people who aren't actually having a heart attack or stroke, e.g., unstable angina or a transient ischemic attack, and those who experience cardiac arrest, will also benefit from faster triage, standard protocols, access to treatments previously unavailable, response time goals, and dedicated resources. Participation in the system is designed to result in faster time to definitive treament, which saves lives and reduces disability. We have some regional data and lots of anecdotal data showing significant reductions in time to treatment. We should have more representative data in 2012.

**Barriers/Issues:**

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Program Application and Hospital Recruitment<br>**Status:** Completed<br>**Time frame:** 7/1/2010 - 8/1/2011<br>**Description:** Develop an application and self-certification process and recruit hospitals to participate in the program. The application will include the cardiac and stroke standards adopted by the Department of Health based on the recommendations of the Emergency Cardiac and Stroke Technical Advisory Committee. Hospitals that want to participate will self-certify they meet the standards to be a cardiac level I or II center or level I, II or III stroke center. | | **Personnel:**<br>- Kelley, Kim<br>**Partners:**<br>- American Heart Association<br>- Emergency Cardiac and Stroke Technical Advisory Committee<br>- Office of Emergency Medical Services and Trauma System<br>**Contractors:** |

**Priority Area : Improve quality of care (prevent first and second events; control risk factors and the diseases)**

## Long Term Objective: Link people to needed personal health services and assure provision of health care.

**Objective**
By 06/2013, increase the number of coordinated and effective statewide heart disease and stroke systems of prevention, screening, diagnosis, treatment and rehabilitation that are available to all citizens from 0 to 1.

**Primary Outcome:** Improve quality of care (prevent first and second events; control risk factors and the diseases)

**Secondary Outcome:** Control high blood pressure

**Status:** In process

**Time frame:** 01/01/2006 - 06/01/2013

**Describe the objective and how it will impact the problem:**
Ensuring widespread use of standards of care in pre-hospital, hospital, and rehabilitation settings may improve outcomes after events.

**06/29/2012:**

**Objective Met:** Currently Ongoing

We are continuing to address community-clinical linkages as part of our overall approach to prevent heart disease and stroke with the activities listed under this objective.

**Barriers/Issues:**

## Long Term Objective: Evaluate effectiveness, accessibility and quality of personal and population-based health services

**Objective**
By 06/2013, increase the number of sets of statewide performance measures from 0 to 1.

**Primary Outcome:** Improve quality of care (prevent first and second events; control risk factors and the diseases)

**Secondary Outcome:**

**Status:** In process

**Time frame:** 07/01/2007 - 06/01/2013

**Describe the objective and how it will impact the problem:**
Washington state lacks a set of comprehensive performance measures in which to evalute the effectiveness of some heart disease and stroke programs, i.e. stroke care. The state's goal is that accessibiilty, effectiveness and quality of care can be measured against statewide CVD performance measures that include established measurement benchmarks.

**06/29/2012:**

**Objective Met:** Currently Ongoing

The evaluation of these services is ongoing through the entire grant period. By hiring a QI Metrics coordinators, we anticipate a greater capacity to evaluate the health services offered.

**Barriers/Issues:**

## Long Term Objective: Improve & strengthen health systems that improve quality of care for CVD and stroke

**Objective**
By 06/2013, increase the number of quality care initiatives from 0 to 2.

**Primary Outcome:** Improve quality of care (prevent first and second events; control risk factors and the diseases)

**Secondary Outcome:**

**Status:** In process

**Time frame:** 07/01/2010 - 06/01/2013

**Describe the objective and how it will impact the problem:**
The goal of this objective is to influence health care systems such as primary care clinics, hospitals, EMS and other professionals through systems/policy change to improve the quality of care delivered for patients with (or at risk for) heart disease and stroke. Tangible mechanisms include the Patient-Centered Medical Home Collaborative that address clinical practice redesign to improve patient outcomes and the creation of the WA Stroke Forum to provide training and infrastructure support to improve stroke systems of care. Related HTN QI indicators are 1.1.1, 1.1.3,1.1.4,1.1.5,1.1.6,1.18,1.19

**06/15/2012:**

**Objective Met:** Currently Ongoing

The Washing Healthcare Improvement network (WHIN), is the Department of Health's newly formed initiative designed to 1) work with primary care organizations and the communities in which they reside to develop and support Patient Centereed Health/Medical Homes,2) Achieve more effective care transitions and care coordination across healthcare settings and providers and 3) provide intensive care management and coordination services for complex patients with multiple medical/behavioral health conditions and psychosocial barriers. These comprehensive programs will launch in November 2012.

**Barriers/Issues:**

## Supporting Objective: Washington State Medical Home Collaborative Expansion

| Objective | Progress | Products |
|---|---|---|
| **Objective**<br>By 06/2013, increase the number of medial home collaborative projects from 1 to 2 within the health care setting (Influencing the general population). | **Status:** In process<br>**Time frame:** 07/01/2009 - 06/01/2013 | - Final Report for September 2009 - September 2011 PCMH Collaborative |

**Describe the objective and how it will impact the problem:**
The Washington State DOH is conducting its 7th Washington State Learning Collaborative which began in June 2009. More than 165 primary care organizations in Washington since 1999 have redesigned their practices with the help of the Washington State Collaborative. Participating clinics have reported improvements in chronic disease indicators including lowering blood pressures, reducing cholesterol levels, and increasing the numbers of people with chronic disease empowered to manage their own health care. This current Collaborative continues to assist 33 teams in redesigning their practices with the same goals of improving chronic disease indicators by assisting practices to create patient-centered medical homes in their practices. The seven principles of a medical home - delivering primary care that is continuous, comprehensive, coordinated, culturally effective, compassionate, accessible, and patient-centered representing approximately 333,000 physician members. The next collaborative projected to start in spring 2012 is being redesigned by the DOH and advisory partners to move beyond a 'Medical Home pilot project' to one that can sustain training and technical assistance for primary care in an increasing number of practices statewide.

**06/15/2012:**

**Objective Met:** Currently Ongoing

Results are available from the conclusion of the Patient Centered Medical Home Collaborative that ended September 2011. See comprehensive report attached. Planning continues for the next iteration and result of this planning is the Washington Healthcare Improvement Network (WHIN), a department of heatlh initiative designed to work with more primary care practices in a shorter amount of time. The number of clinics that we hope to support over the collaborative year are 300 clinics through intensive programing or through self-paced statewide efforts. WHIN, in collaboratiion with local health and community orgaanizatinos will provide training and technical assistance to practices interested in pursuing or advancing the pateint centered health/medical home model.

**Barriers/Issues:**

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Support planning and implementation of the WA State Medical Home Collaborative expansion<br>**Status:** In process<br>**Time frame:** 12/1/2010 - 6/1/2013<br>**Description:** The HDSP Quality Improvement Coordinator will continue to provide technical assistance, consultation and coaching to current collaborative clinics while providing planning and design support to help expand the next iteration of the MH collborative. | **12/20/2011:**<br>The Washington Patient Centered Medical Home Collaborative came to a close in September 2011 with 33 practice teams many representing large organizations making changes to their systems of care to improve the care of patients they see including primary prevention including hypertension and cholesterol and chronic disease. The final report will be available towards the end of the fiscal year in 2012 and will be provided in final reporting. Currently, extensive work is occurring to design what the next phase of practice support (collaboratives) will look like....going to the health systems (regionally) and reaching more practices and the communities in which they practice including addressing hospital and ER admissions and 30 day readmissions.<br>**6/15/2012:**<br>Results are available and on average, the overall score for medical home indicators improved over teh two year collaborative. See final report in attachments. Planning continues on next iteration of work and two regions in the state have been identified as the intial sites for intensive support launching in November 2012. A statewide self paced program | **Personnel:**<br>- Rush, Colette<br>- Shields, Anne<br>**Partners:**<br>- Asthma Program<br>- Diabetes Prevention and Control Program<br>**Contractors:** |

will be implemented at the same time.

## Long Term Objective: Inform, educate, and empower people about recognizing heart attacks and strokes

**Objective**
By 06/2012, increase the number of environmental support tools from 0 to 1.

**Primary Outcome:** Know signs and symptoms, and importance of calling 9–1–1

**Secondary Outcome:** Improve Emergency Response

**Status:** Completed

**Time frame:** 07/01/2010 - 06/01/2012

**Describe the objective and how it will impact the problem:**
In Washington, only 13% of BRFSS respondents correctly identified all five of six as symptoms of heart attack listed, and only 11% correctly identified all five of six as symptoms of stroke listed. Additionally, a commonly quoted statistic is that more than 50% of heart attack and stroke patients do not call 911, thus do not activate Emergency Medical Services (EMS) and arrive at the hospital on their own (thereby increasing risk of mortality and morbidity).

**06/29/2012:**

**Objective Met:** Yes

Over the years, we have completed and reported on numerous public education projects on signs and symptoms of heart attack and stroke and the importance of calling 911. Two policy changes that ensure sustained education efforts are the requirements that hospitals participating in the emergency cardiac and stroke system (96% participation, covering nearly every county in the state) 1) educate the public on signs and symptoms annually, and 2) collect data on mode of transportation to the hospital. We will continue to work with our partners to support efforts to educate the public on these important topics as opportunities arise.

**Barriers/Issues:**

## Supporting Objective: Environmental Changes:Signs of Heart Attack, Stroke, Importance of calling 911

| Objective | Progress | Products |
|---|---|---|
| **Objective**<br>By 06/2014, increase the number of statewide HDSPP sponsored efforts to support environmental changes that encourage knowledge of the signs of heart attack and stroke and the importance of calling 911 from 1 to 2 within the community, health care and work site settings (Influencing the general population). | **Status:** In process<br>**Time frame:** 01/01/2011 - 06/01/2014 | - Cardiac Stroke Network<br>- Heart Attack Signs and Symptoms PSA<br>- Interview with Dr. David Tirschwell<br>- Stroke Public Education Toolkit<br>- Stroke Signs and Symptoms Public Service Announcement |

**Describe the objective and how it will impact the problem:**
By 06/2014, increase the number of statewide HDSPP sponsored efforts to support work site environmental changes that encourage knowledge of the signs of heart attack and stroke and the importance of calling 9-1-1 from 0 to 1 within the work site setting (Influencing the general population).

**12/01/2011:**

**Objective Met:** Currently Ongoing

HDSPP posters that show the signs of heart attack and stroke continue to be posted in work site and community centers New: approximately 300 posters (for approximately 30 sites that each reach over 100 people a year) are now posted in health care (primarily hospital sites) sites across Washington.

**Barriers/Issues:**

**06/29/2012:**

**Objective Met:** Currently Ongoing

Over the years, we have completed and reported on numerous public education projects on signs and symptoms of heart attack and stroke and the importance of calling 911. Two policy changes that ensure sustained education efforts are the requirements that hospitals participating in the emergency cardiac and stroke system (96% participation, covering nearly every county in the state) 1) educate the public on signs and symptoms annually, and 2) collect data on mode of transportation to the hospital. We will continue to work with our partners to support efforts to educate the public on these important topics as opportunities arise. Further efforts in the worksite setting are under discussion and ongoing.

**Barriers/Issues:**

| Activity | Progress | Resources |
|---|---|---|
| **Title:** TA, training:environmental changes: Signs of Heart Attack, Stroke, Importance of Calling 911<br>**Status:** Completed<br>**Time frame:** 1/1/2011 - 6/1/2012<br>**Description:** Provide Washington-based health care, community, and work sites, with environmental support tools such as poster signage for the warning signs of heart attack and stroke and the need to call 9-1-1. Also provide training, technical assistance and consultation as needed. | **12/1/2011:**<br>HDSPP posters that show the signs of heart attack and stroke continue to be posted in work site and community centers New: approximately 300 posters (for approximately 30 sites that each reach over 100 people a year)are now posted in health care (primarily hospital sites) sites across Washington.<br>**5/31/2012:**<br>We had a series of conference calls with stroke coordinators to develop and share public education activities for May stroke month. A public education toolkit was developed as a result of these calls. See products.<br>**5/31/2012:**<br>We continue to promote the signs and symptoms resources on the Cardiac and Stroke Network website that was developed in a four county area with support from the Department of Health, | **Personnel:**<br>- Saunders, Rachel<br>**Partners:**<br>**Contractors:** |

| | | |
|---|---|---|
| **Title:** TA, training:environmental changes: Signs of Heart Attack, Stroke, Importance of Calling 911<br>**Status:** Completed<br>**Time frame:** 1/1/2011 - 6/1/2012<br>**Description:** Provide Washington-based health care, community, and work sites, with environmental support tools such as poster signage for the warning signs of heart attack and stroke and the need to call 9-1-1. Also provide training, technical assistance and consultation as needed. | American Heart Association, and a grant from Premera. See products for website. | |

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Stroke Month Toolkit<br>**Status:** Completed<br>**Time frame:** 1/1/2012 - 5/1/2012<br>**Description:** Develop a stroke public education toolkit for Stroke Month May 2012 to include educational tools, resources for materials, sample press release, sample proclamation, and other resources. | **4/15/2012:**<br>Stroke month toolkit completed and disseminated to stroke coordinators in 70 of 85 hospitals in the state and EMS regional councils. This toolkit will also be used for the Stroke Coordinator Best Practices Forum in September 2012, and be posted on the Emergency Cardiac and Stroke website. | **Personnel:**<br>- Kelley, Kim<br>**Partners:**<br>- American Heart Association<br>**Contractors:** |

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Stroke Signs and Symptoms Public Service Announcement<br>**Status:** Completed<br>**Time frame:** 1/1/2012 - 4/1/2012<br>**Description:** Develop and have aired a PSA on stroke signs and symptoms. | **5/10/2012:**<br>PSA completed and airing started. | **Personnel:**<br>- Kelley, Kim<br>**Partners:**<br>- American Heart Association<br>**Contractors:** |

| Activity | Progress | Resources |
|---|---|---|
| **Title:** Heart Attack Signs and Symptoms Public Service Announcement<br>**Status:** Completed<br>**Time frame:** 12/1/2011 - 2/1/2012<br>**Description:** Develop a heart attack signs and symptoms PSA and get it aired as frequently as possible. | **2/15/2012:**<br>PSA developed and airing started. | **Personnel:**<br>- Kelley, Kim<br>**Partners:**<br>- American Heart Association<br>**Contractors:** |