A Social Network Analysis and Qualitative Assessment of Partnerships for Million Hearts®

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Preface

To address the severity of cardiovascular disease (CVD) in the United States, the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) implemented Million Hearts® (MH), an initiative focused on strengthening and supporting partnerships to promote cardiovascular health. MH partners aim to decrease the incidence of heart attack and stroke by reducing smoking, reducing sodium intake, and eliminating artificial trans fat intake through initiatives to improve access to care, improve the quality of care for the ABCS (aspirin when appropriate, blood pressure control, cholesterol management, and smoking cessation), focus clinical attention on the prevention of heart attack and stroke, and activate the public to lead a heart-healthy lifestyle. Networks such as MH involve the coordination of public, private, and nonprofit entities around a shared goal and are viable strategies for addressing complex public health issues.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the CDC contracted with RAND and the University of Colorado at Denver to examine the partnerships leveraged for MH. The primary goals of this research were to describe the partnerships developed in MH—including the strength and level of interactions among partners—and to define the practices, activities, and approaches to CVD prevention that occurred as a result of the program. The ASPE and CDC were also interested in identifying what is working with the MH approach—including identifying the facilitators of and barriers to strong partnerships and assessing how MH partners interact to work toward achieving CVD prevention goals.

This final report presents the results of this research and some key suggestions for future potential MH activities. This report will be particularly useful to the Million Hearts leadership and members of the national network. It provides insights into the interactions of partners and highlights points of consideration for strengthening the network, organizing activities, disseminating findings, and leveraging the resources of all MH participants. Organizations currently involved in implementing MH activities at any level (local, state, or national) or those interested in joining the MH network will find value in these results. This report highlights for them how MH activities are organized, the goals being achieved, and how partners intersect to address CVD. Although the data are drawn from partners within the broader MH network, the results are also useful to any organization or set of organizations interested in CVD prevention, because the lessons learned are broadly applicable to community-based approaches to disease prevention and health promotion.

This work, sponsored by the ASPE, was conducted in RAND Health, a division of the RAND Corporation.
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Summary

Introduction

To address the severity of cardiovascular disease (CVD) in the United States, the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) implemented Million Hearts® (MH), an initiative focused on strengthening and supporting partnerships to promote cardiovascular health. MH partners aim to decrease the incidence of heart attacks and strokes by reducing smoking, reducing sodium intake, and eliminating artificial trans fat intake through initiatives to improve access to care, improve the quality of care for the ABCS (aspirin when appropriate, blood pressure control, cholesterol management, and smoking cessation), focus clinical attention on the prevention of heart attack and stroke, and activate the public to lead a heart-healthy lifestyle. Networks like MH involve the coordination of public, private, and nonprofit entities around a shared goal and are viable strategies for addressing complex public health issues.

In consultation with CDC, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the CDC contracted with RAND and the University of Colorado at Denver to examine the partnerships leveraged for MH. The primary goals of this research were to describe the partnerships developed in MH—including the strength and level of interactions among partners—and to define the practices, activities, and approaches to CVD prevention that occurred as a result of the program. The ASPE and CDC were also interested in identifying what is working with the MH approach—including identifying the facilitators of and barriers to strong partnerships and assessing how MH partners interact to achieve CVD prevention goals.

To accomplish the goals, the study relied on a mixed-methods approach that included an environmental scan of the published and gray literature and of documents and descriptions of MH projects on organizational websites; key informant interviews with MH subject-matter experts (SMEs); and a social network analysis (SNA) of the organizations that make up the national MH partnership that used the PARTNER (Program to Analyze, Record, and Track Networks to Enhance Relationships) tool. As we present results, we refer to the subjects of this research in different ways. The terms interviewee or respondent refer to participants in either the interviews or SNA. The respondents for these two research methods were drawn from organizations affiliated with Million Hearts. Thus, we sometimes refer to them as partners, especially to illustrate when findings relate back to the partnership. Finally, the environmental scan synthesizes information from many different and largely local partnerships. Members of these networks are also referred to as partners. Although these local organizations may not be members of the national MH partnership, we use information from the scan to help paint a clearer picture of how MH activities extend into local CVD prevention activities.
Key Findings

Our findings derive from synergistic use of our methods and focus on (1) assessing how MH partners are connected and the activities they are engaged in to achieve CVD prevention goals; this includes defining the practices, activities, and approaches to CVD prevention that encompass MH; (2) identifying what is working with the MH approach, including facilitators of and barriers to strong partnerships; and (3) assessing how MH partners interact to work toward achieving CVD prevention goals.

Assessing Partnership Engagement Process and Level and Strength of Interaction Among Partners in Million Hearts

One of the primary aims of this research was to assess how the various organizations that compose MH are connected, identify the approaches they are taking to address CVD prevention in their communities, and assess how they interact to achieve these goals. Data from all three research approaches informed these issues.

Across the three research methods, we identified many ways that the organizations have built local networks of partners to implement MH priorities and activities. We found that the bulk of the MH partnerships and activities we identified occurred at the local level and often do not have a direct association with organizations involved in the core national MH partnership, which is composed of federal agencies and national associations with interests in CVD and related conditions and various health care systems and practices. All are clearly inspired by the national partnership and its goals, but many develop without direct assistance from national partners. Nevertheless, the national partnership is developing resources (information, tools, branding, and so on) that are being used to support the work of these local initiatives—with information sharing being the primary activity of partners. Further, the SNA discovered that engagement among partners is positive, with high levels of trust and value. As a result, partners indicated that participation in the network was beneficial to their organizations. This indicates that the goal of Million Hearts is to bring a group of diverse stakeholders together to address issues of CVD has been successful at the national level.

Assessing What Is Working with the Million Hearts Approach and Identifying the Facilitators of and Barriers to These Successes

Another major aim of this research was to identify what is working with the MH approach, including the specific facilitators of (and barriers to) successfully implementing MH activities. Several points of data from our mixed-methods approach helped to answer this question.

We found some evidence that MH partners perceive that they are achieving CVD prevention and process improvement outcomes and that MH partners are working to strengthen their partnerships to achieve these goals. Some respondents reported in the interviews that the MH approach of building partnerships was a particular strength that helped them achieve their CVD
prevention goals. As a result of participating in MH, some respondents identified changes to their CVD prevention activities, including focusing on raising awareness of the ABCS (aspirin when appropriate, blood pressure control, cholesterol management, and smoking cessation), providing resources for sharing among stakeholders, developing new programs, and facilitating communications between sectors and agencies. These successes were facilitated by an alignment of goals among partners, the attainment of buy-in from the organizational leadership of participating organizations, good communication between partners, diverse partner sets, trust, the recognition and leveraging of the resources of other members, and funding. Barriers that MH leadership might address to further leverage the resources of its partnership included a lack of direct funding, difficulties with bringing partners to the table, a lack of experience among partners, and different perspectives on CVD prevention among partners. Further, there was some concern that more could be done to identify how to operationalize MH activities at the local level. While these barriers are not uncommon in other networks, they could signal avenues that MH leadership can address for future iterations of Million Hearts.

Assessing How Million Hearts Partners Are Connected and the Activities They Are Engaged in to Achieve Cardiovascular Disease Prevention Goals

Another important research aim was to identify how MH partners interact to achieve their CVD prevention goals. To address this aim, we use all three of our methods to emphasize the specific details among partners of the MH network in a nuanced way.

We found that the MH network effectively enables a diverse, cross-sector group of federal and private-sector partners to share information about issues related to cardiovascular health. Participation in the network requires only minimal resources for partners, but the return in terms of trust and value among members is high. These results demonstrate that the network has created an effective information-sharing platform. The fact that these activities are reported with or without CDC or CMS leadership demonstrates an important quality: the network does not depend on these two federal agencies to achieve its goals. In the future, if the MH network leadership decides that the network should articulate goals beyond information sharing, there appears to be a foundation that can be built on to achieve additional goals. Developing a diverse network of partners that trust and value one another while engaging in information-sharing activities is an achievement in and of itself. Morphing this network into other structures and other purposes could be a strategic next step.

Conclusions and Suggestions for Next Steps

The Million Hearts network has been successful in many ways, particularly in engaging a diverse group of public and private partners in collectively addressing issues related to CVD. As an information-sharing network, MH has succeeded in reaching this goal. Keeping the network intact, as is, can have some tangible benefits without a lot of additional resources or change.
However, there are still some suggestions that MH leadership may want to consider to strengthen the current level of commitment and activity from its membership. The suggestions are listed in order of the complexity of implementation, with the least complex suggestions listed first:

1. Maintain current programming, but leverage existing activity and resources, such as by developing a list of current best practices in MH and disseminating these within the network.
2. Maintain current activity, but focus on strengthening current levels of commitment and engagement among members. For example, forums can be constructed to share success stories and other lessons learned among partners.
3. Reevaluate current activities, focusing on some partner-generated activities, such as measuring the impact of MH on CVD outcomes.
4. Review the purpose of MH and consider revising goals, member expectations, or governance. For example, evaluate whether the current levels and types of interactions in the network match the expected types of interactions among partners.
5. Develop diversified funding strategies to support MH work, such as by providing small, one-time funding opportunities to focus on a single policy or program.
6. Adopt other strategies for sustainability suggested by partners, such as providing specific guidance on implementing strategies at the local level.

More detail on these suggestions is provided in Chapter Six.
Acknowledgments

We gratefully acknowledge a number of people whose tremendous amount of time and expertise generously contributed to the creation of this report. First, many thanks to the leaders and key informants at the local, state, and federal organizations we interviewed and surveyed during this study for sharing insights about their work around improving CVD prevention and the impact they are having in their local communities and at the state and federal levels. We are grateful to Dr. Darwin Labarthe, MD, Ph.D., professor of preventive medicine, and Dr. Lois Davis, Ph.D., senior policy researcher at RAND, for their thoughtful review and feedback during preparation of this report. Their insights improved this work tremendously. Additionally, we would like to thank the following individuals who worked as part of our technical working group (TWG) and provided thoughtful input on the contents of this report: Judy Hannan, CDC; Patricia Markovitch, CMS; Amber Stolp, CDC; Hilary Wall, CDC; and Janet Wright, CDC. The TWG was instrumental in identifying MH practices and staff at the various agencies to interview. It also reviewed findings at each stage of the research to ensure that they were appropriately contextualized and helped us identify steps to take to make sure our research methods added value. The findings and conclusions of this article are those of the authors and do not necessarily represent the official position of the U.S. Department of Health and Human Services, U.S. Centers for Disease Control and Prevention or the Office of the Assistant Secretary for Planning and Evaluation.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABCS</td>
<td>aspirin when appropriate, blood pressure control, cholesterol management, and smoking cessation</td>
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<tr>
<td>AHA</td>
<td>American Heart Association</td>
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<tr>
<td>ASPE</td>
<td>Office of the Assistant Secretary for Planning and Evaluation</td>
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<td>ASTHO</td>
<td>Association of State and Territorial Health Officials</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CDP</td>
<td>chronic disease prevention</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<td>CVD</td>
<td>cardiovascular disease</td>
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<tr>
<td>EHR</td>
<td>electronic health record</td>
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<tr>
<td>FQHC</td>
<td>federally qualified health center</td>
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<tr>
<td>MH</td>
<td>Million Hearts®</td>
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<tr>
<td>PARTNER</td>
<td>Program to Analyze, Record, and Track Networks to Enhance Relationships</td>
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<tr>
<td>QI</td>
<td>quality improvement</td>
</tr>
<tr>
<td>QIDE</td>
<td>Quality Insights of Delaware</td>
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<tr>
<td>SME</td>
<td>subject-matter expert</td>
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<td>SNA</td>
<td>social network analysis</td>
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<tr>
<td>TWG</td>
<td>technical working group</td>
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1. Introduction

Background

More than 800,000 people die each year from a stroke or heart attack, making cardiovascular disease (CVD) the leading cause of death in the United States. To help address this issue, the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) launched Million Hearts® (MH) in 2011, an initiative to coordinate efforts across the United States to prevent “1 million heart attacks and strokes by 2017.” MH seeks to nurture and influence partnerships to promote cardiovascular health through a series of public-private partnerships focused on community-based prevention to decrease the incidence of heart attacks and strokes by reducing smoking, reducing sodium intake, and eliminating artificial trans fat intake. MH also aims to improve management and quality of care for the ABCS (aspirin when appropriate, blood pressure control, cholesterol management, and smoking cessation), which can potentially prevent more deaths than other clinical preventive services (Frieden and Berwick, 2011). MH has set a goal to meet targets established by Healthy People 2020 and is building cohesive partnerships to achieve this goal. Examples of Healthy People 2020 heart disease and stroke prevention goals include the following (Office of Disease Prevention and Health Promotion, 2017):

- Reduce the proportion of persons in the population with hypertension.
- Increase aspirin use as recommended among adults with no history of CVD.
- Increase the proportion of adults age 20 years and older who are aware of the symptoms of and how to respond to a heart attack and/or stroke.
- Reduce hospitalizations of older adults with heart failure as the principal diagnosis.

A key strategy for achieving these targets is to implement policies to coordinate the public, private, and nonprofit sectors around these shared goals. This type of coordination could scale up the adoption and dissemination of proven clinical and community strategies to prevent heart attacks and strokes through relationship building, resources and knowledge exchange, program development, data sharing, and the identification of best practices.

The MH model of developing public-private partnerships to address health concerns such as CVD, often referred to as “network interventions,” is one that communities are increasingly adopting to address complex public health issues (O’Leary and Bingham, 2009). But while there is an identifiable consensus in the literature that networks are a viable and often successful strategy for achieving organizational goals, it is unclear what makes them successful, what
factors facilitate or pose barriers to participation by potential partners, what the best strategies are for keeping partners engaged, or how best to structure the partnership to achieve its goals.

The MH network is complex, involving leadership from CDC and CMS and participation by a host of federal and private-sector agencies. In total, the MH network has more than 100 named partners at multiple levels inside and outside the public health and health care systems. There are also an unknown number of organizations and local partnerships that define their CVD prevention activities under the rubric of MH but are not active participants in the national partnerships. In these cases, it is not clear what aspects of MH keep them engaged. As this network has grown, there is a corresponding need to develop an evidence base regarding what practices exist and what factors are associated with the successful implementation of the partners’ activities.

Objectives and Approach

In consultation with CDC, ASPE contracted with RAND and the University of Colorado at Denver to examine the partnerships leveraged for Million Hearts. The primary aims of this research were to describe the partnerships developed in MH—including the strength and level of interactions among partners—and to define the practices, activities, and approaches to CVD prevention that occurred as a result of the program. We also sought to identify what is working with the MH approach—including identifying the facilitators of and barriers to strong partnerships and assessing how MH partners interact to work toward achieving CVD prevention goals.

To accomplish these aims, the study relied on a mixed-methods approach that included an environmental scan of the published and gray literature and of documents and descriptions of MH projects on organizational websites; key informant interviews with MH subject-matter experts (SMEs); and a social network analysis (SNA) of the organizations that make up the national MH partnership that used the PARTNER (Program to Analyze, Record, and Track Networks to Enhance Relationships) tool. More detail on the methods and their relationship to the aims of the study is provided in Chapter Two. Here, we summarize the mixed-methods approach. We view these methods as interrelated and synergistic in allowing us to address the three study aims.

The environmental scan was a key first step in our analysis of how MH partnerships are formed and sustained. MH partnerships occur at multiple levels, but many are clearly local in scope. The scan focused on describing the development of partnerships and other activities to address CVD at all levels—local, regional, state, and national; highlighting the facilitators of and barriers to their engagement and connections; and, where available, summarizing the self-reported outcomes of these efforts. These largely local efforts may not be formally represented in the national MH partnership, but describing their activities highlights in more depth how MH approaches are implemented in local communities. The scan also informs our overall approach to both the key informant interviews and the SNA. The projects and partnerships the
The overarching assessment of MH seeks information on a number of questions about the impact of MH on CVD prevention activities that cannot be answered by the environmental scan alone. Thus, we engaged SMEs around the country in key informant interviews to provide more nuanced information about MH, such as how partners work together to address the aims of MH, the extent to which their work has changed as a result of participation in MH, and how they attain and sustain adequate resources to participate in MH. This qualitative data collection and analysis was also designed to shape the sampling frame for the SNA and develop themes (e.g., barriers to and facilitators of MH relationship-building and collaborative activities) to help guide our SNA analysis.

Using the data and information gathered from the literature and our communication with the ASPE and CDC project team, we identified a cohort of stakeholders, leaders, and policymakers from state, local, and national organizations who were considered integral players in the success of MH within their independent organizations and in the overall MH network. The interview protocol was designed to elicit the maximum amount of information about the facilitators of and barriers to establishing partnerships, identify effective practices, and develop illustrative narratives that demonstrated the impact of the policies and programs of Million Hearts.

The SNA we conducted was designed to identify the MH relationships and develop an evidence base for future systems-building efforts. For the SNA, we used PARTNER (Varda et al., 2008) to define the strength and direction of relationships, identify partner value attributes, and assess partner trust. This tool allows us to define more concretely how the organizations involved in the national MH partnership are connected and the extent to which they plan and implement CVD prevention programs together. It also helps in understanding their perspectives on how participation in MH has impacted their capacity to achieve CVD prevention goals.

At each stage of the research, we engaged members of the project’s technical working group (TWG). The TWG was selected by the ASPE and CDC project team and is composed of experts from the CDC and CMS who work most closely with the national MH partnership. Their roles included helping to define where we searched for documents for the environmental scan, identifying SMEs to participate in the interviews, and highlighting organizations by their contributions to MH to create a sampling frame for this research. In addition, they reviewed our findings to help provide context for the results.

Scoping

There are several issues related to the scope of this research. Although we used a mixed-methods approach to identify information about MH, this is not an evaluation of the changes that occurred in local and national CVD prevention programming, because our data collection occurred after the start of the five-year period of MH. Further, we limited our definition of the
MH network to organizations with the most active engagement in the national planning process but found that Million Hearts has connections to many different organizations and partnerships around the country. Understanding how each of these approaches is developed, the progress they have made toward MH goals, and how they are connected to one another and the national program would provide much deeper information about the MH network than that provided by our environmental scan and in-depth analyses of the national network alone; however, examination of these factors was beyond the scope of this study. We have identified novel information about the development and growth of a diverse range of MH activities, but it is not possible to evaluate the effectiveness of these activities without formal outcome evaluations. Our environmental scan was further limited by the fact that we reviewed only practices for which written documentation is available; there are potentially many other activities that are not as formally documented. This may be especially true of activities that have been considered failures by sponsors or participants, perhaps suggesting why information on barriers to implementation and partner interactions is harder to find. Further, although we do not have strong information about the timelines of these activities, MH is a relatively new approach, and conclusions drawn at this stage may not be relevant down the line.

Despite these limitations, we were able for the first time to highlight the range of practices that occur under the rubric of MH, facilitators of the development of these approaches, and a great deal of information about what partners appreciate about MH, including its leadership style and overall approach. This is because we were able to identify the core set of partners at the national level that are active in MH and that work together to produce tools and other resources to share within the partnerships. As a network, MH is unique with respect to its organization, activities, and leadership. Thus, information derived from the partners is critical for considering next steps. The strength of this report is that we combine a rigorous approach with information specific to the national MH partnership’s practices and policies that is derived from the partnership itself in order to develop insights about how MH can continue to grow.

Organization of This Document

In Chapter Two, we summarize the three methods used in our analysis in more detail than is covered in this chapter. Those wishing to focus on the results of the analysis can focus on Chapters Three through Five, where we present our findings that derive from synergistic use of our methods. Specifically, Chapter Three assesses the partnership engagement process and the level and strength of interaction among partners in MH; Chapter Four identifies whether MH is achieving its goals, how MH partners have changed their activities as a result of participation in MH, and the facilitators of and barriers to these successes; and Chapter Five assesses how MH partners interact to achieve CVD prevention goals. Following that, we present our overall conclusions and suggestions for potential next steps for Million Hearts.
2. Mixed Methods Used in Analysis

As noted in Chapter One, we used a mixed-methods approach in conducting the analysis to accomplish the three aims of the study. In this chapter, we explain the environmental scan, the key informant interviews, and the SNA in more detail. In Chapters Three through Five, we discuss the results derived from the synergistic use of these three methods.

Throughout this report, we refer to the subjects of this research in different ways. We use interviewee or respondent to refer to participants in either the interviews or the SNA. Because the subjects of these two research methods were all drawn from organizations with an affiliation to Million Hearts, we sometimes refer to them as partners of MH or just partners. Typically, we do this when describing how the findings relate back to the national MH partnership. Moreover, findings from the environmental scan are drawn from write-ups of many different and largely local partnerships. Members of these networks are also referred to as partners. We draw lessons from all three methods to inform our understanding of MH.

The Environmental Scan of Million Hearts Partnerships and Activities

The environmental scan identified the range of practices developed or supported by MH, who the participating organizations are, and the facilitators of and barriers to these activities. It helps answer a subset of the project’s key research questions:

- What strategies were most effective and useful in creating and sustaining MH partnerships?
- How are partner efforts coordinated, including evidence of the development of shared goals and vision?
- What strategies did MH partners use to disseminate and promote the diffusion of evidence-based CVD prevention strategies, tools, and messages to their networks?
- How does network functioning impact outcomes?

We carried out literature and web-based searches to identify MH-related partnerships and activities discussed in the literature in consultation with the TWG. We used information from the environmental scan to categorize the goals and outcomes of the multiple partnerships and networks within Million Hearts. The scan also describes various interventions and programs developed by several partners and networks for a targeted audience, including particular patient populations, communities, or physicians. Additionally, the scan underscores a variety of strategies to support partners in different capacities.

To conduct the environmental scan, we reviewed websites, the peer-reviewed and gray literature (e.g., reports and proceedings), and other materials that summarized MH activities.
We looked specifically for articles that described the partnerships that are leveraged to address CVD prevention. We developed several combinations of key terms and search strategies (e.g., searching through key partner websites for papers and reports) to best identify partner organizations and their MH-related activities. Discussions with members of the project’s TWG provided additional insight on where to find documentation on MH, the scope of partnerships in the MH network, and their take on how MH activities have been evaluated. These discussions were useful in guiding and directing our search for pertinent information to include in the environmental scan and in confirming data collected in the environmental scan.

To identify websites and peer-reviewed articles and to search the gray literature, the study team relied on the following databases: Google Scholar, PubMed, and Web of Science. We searched for articles that appeared in the five-year period between 2010 and 2015. The team also systematically searched the websites of the key MH federal, national nongovernmental, and state partners.

Our search terms for both the gray and peer-reviewed literature included the following phrases: Million Hearts, public health partnerships, prevention, cardiovascular disease, community-based partnerships, and ABCS. These were searched independently and in combination with each major partner organization of MH. The full list of partnering organizations is presented in Appendix One.

We created a spreadsheet to catalog the information from the web and journal scan with data abstraction fields to capture the information shown in Table 2.1.

<table>
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<th>Table 2.1. Cataloging Information from Environmental Scan</th>
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<tbody>
<tr>
<td><strong>Partnership data</strong></td>
</tr>
<tr>
<td>• Report title (when applicable)</td>
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<tr>
<td>• Partners or stakeholders involved</td>
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<tr>
<td>• Level of partners (local, state, national)</td>
</tr>
<tr>
<td>• Level of involvement of partners</td>
</tr>
<tr>
<td>• Audience for partnership’s activities</td>
</tr>
<tr>
<td>• Timeline of partnership</td>
</tr>
<tr>
<td><strong>Sustaining networks and partnerships</strong></td>
</tr>
<tr>
<td>• Facilitators to stakeholder engagement and connections</td>
</tr>
<tr>
<td>• Barriers to stakeholder engagement and connections</td>
</tr>
<tr>
<td><strong>Network activities</strong></td>
</tr>
<tr>
<td>• Goals or activities of partnership</td>
</tr>
<tr>
<td>• Partnership products</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
</tr>
<tr>
<td>• Self-reported outcomes&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Self-reported information on the impact of the partnership on outcomes&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup> Describes self-reported measured effects of MH activities at the patient and practice level (e.g., improved hypertension control or improved quality of cardiovascular care). We report findings as reported by the partnerships. Once again, it was outside the scope of this project to verify these data or assess the quality of their measurement efforts.

<sup>b</sup> Describes specific aspects of the partnership that impacted outcomes (e.g., frequent partner communication).
In addition to capturing the information in Table 2.1, we also captured strategies to disseminate evidence-based messages and tools to networks and approaches to evaluating networks. Team members then abstracted information from each article into the spreadsheet and summarized trends across all documents obtained in the scan.

These searches generated 281 articles, reports, and web documents that mentioned or were related to MH activities and partnerships. We kept only articles and documents that described (at least in part) some aspect of the initiative rather than merely mentioning it. From this smaller list of 119 articles and documents, we further eliminated 35 articles for several key reasons: (1) they were “aspirational” articles that highlighted the goals and mission of MH but did not talk specifically about current activities related to MH and were too general in scope; (2) they did not discuss specific partnerships and lacked substantive information on MH networks; or (3) they were duplicate articles generated from multiple web searches and databases. In the end, we identified documents that describe 74 unique partnerships and other MH activities across the country. Appendix Two contains a table with a subset of the data identified in Table 2.1 that describes these activities and includes information on the key partners involved, goals and activities of each partnership, and the setting and audience for the activities.

Key Informant Interviews

To gain a more nuanced understanding of the larger Million Hearts network, it was important to gather the perspectives of a diverse sample of stakeholders, leaders, and policymakers integral to the planning and implementation of MH. The results from the environmental scan guided us in this effort by identifying local, state, and national organizations that were influential players in the MH network. We then worked with the project team (composed of representatives from the ASPE and CDC) to fill in any gaps and to identify key individuals from these organizations.

The key informant interviews were designed to address questions about which organizations are part of the larger MH network, how members of the network are connected, and their perspectives on goals, outcomes, barriers, successes, and the status of relationships among the partners. They also allowed us to develop a deeper understanding of the extent to which their work has changed as a result of participating in MH and how they attained and sustained adequate resources to participate in MH.

Methods

Interview Sample

To develop our recruitment list of MH partners for the interviews, we cross-referenced three main sources: (1) the list of federal and nonfederal (private-sector, state, and local) organizations that join one of two regular MH calls; (2) direct consultation with the project team (which consisted of staff from RAND, the University of Colorado at Denver, the ASPE, the CDC, and the members of the TWG) on how active each organization has been on these MH calls and with
MH activities overall (particularly, activities that support the overall MH network); and (3) organizations we identified in our environmental scan as key participants in MH activities.

Our overall goal was to recruit a broad cross section of partners with different patterns of engagement with Million Hearts, spanning organizations

- that joined MH earlier and those that joined later (including those that “self-started” and were later incorporated by MH)
- that received funding for Million Hearts versus those without funding
- that were very active and those with closely aligned mission sets that were less active
- that had a wide spectrum of responsibilities, including regulatory agencies, educational institutions, provider groups, and insurers.

Selecting Federal Organizations

Our initial list of federal organizations included those that have been identified as key MH partners in public documents, including the MH website, and those partners that have been involved in the MH network regular phone calls for federal MH partners. The project team identified on this list which organizations were either (a) particularly active on the phone calls and associated collaborative activities or (b) less active but had a unique perspective or type of involvement with Million Hearts.

To identify how MH activities are supported by the national MH network, we asked the project team to define the range of these activities and the participants. They provided a list of activities across three main categories:

- **Information sharing** (e.g., social media engagement, adoption of MH content on websites, presentations at national conferences, etc.)
- **Joint development of programs** (e.g., CMS’s involvement in creating 100 Congregations for Million Hearts, or the Health Resources and Services Administration’s collaboration with the National Association of Community Health Centers)
- **Technical assistance to MH projects** (e.g., CMS and the Center for Medicare & Medicaid Innovation’s provision of assistance to the Million Hearts Cardiovascular Risk Reduction Model)

Using these inputs, we created a list of federal organizations that (a) participated regularly in the MH conference calls or had a unique perspective to share and (b) participated in identifiable activities that support the MH network, whether through information sharing, joint development of programs, or technical assistance. We also asked the project team to help us develop a list of federal organizations with mission sets closely aligned or highly overlapping with the initiative that were less active on MH calls and less active in MH activities. Overall, our list included 26 federal organizations.
Selecting Nonfederal Organizations

Similar to the process for selecting federal organizations, to identify nonfederal organizations, we began with the list of state, local, and private-sector organizations listed as participants on the regular Million Hearts call for partners in the private sector. The project team identified on this list which organizations were either (a) particularly active on the phone calls and associated collaborative activities or (b) engaged in an MH cooperative agreement. Also, in parallel with the federal organization recruitment process, we asked the project team to identify the private-sector partners that participated in MH collaborative activities—through sharing information, developing programs, or providing technical assistance. Additionally, we noted the state, local, and private MH partner organizations that appeared in our environmental scan.

To verify and complement this list, we asked the TWG to provide insights on the list of private-sector organizations describing their involvement in MH activities and their potential perspective on MH. In several cases, we felt that this information identified organizations with a unique perspective on the MH partnership that we should include in the interviews. These perspectives centered on two main themes: (1) the organization has a strong presence in the network through its activities (some of which are jointly developed with other organizations), or (2) the organization may be less engaged than others but has a perspective on the history and growth of MH and on why some organizations with congruent missions to MH’s do not participate. This resulted in a list of 31 private-sector organizations.

Recruitment Process

Recruitment began with the CDC and ASPE reaching out to the main contacts at both the federal and nonfederal organizations on the list to indicate an impending request for an interview about Million Hearts; this also involved asking them to nominate alternative or additional respondents from their organization if talking to them was not feasible or adequate to identify the range of activities and attitudes about participating in MH activities.

RAND then sent a follow-up request by email to schedule an interview by telephone. If neither approach was successful, key members of the TWG followed up by phone in a third and final attempt to reach the most critical organizations to participate in the interviews.

Interviews were conducted either with individual respondents or with groups of respondents at the discretion of the individual organizations and as allowed by individuals’ schedules at these organizations. If we discovered from our contacts at federal or nonfederal organizations that we should be speaking separately with different divisions, departments, or programs within the organization, we attempted to schedule these as separate interviews.

In total, 57 organizations were invited to participate, and we interviewed representatives from 51 different organizations, for a response rate of 89 percent. Table 2.2 shows the distribution of these organizations by geographic level (local, state, regional, and national) and type (government, nonprofit, and for profit). Overall, we conducted approximately half (25 out of 51) of our interviews with federal government institutions and the remaining half (26 out of 51) with other
types of organizations, including three state, two local, and one regional government entity. Most of the remaining interviews (19 out of 51) were with representatives of nonprofit organizations. As with government interviews, most of these interviews with nonprofit organizations (14) were at the national level. We also conducted three interviews with nonprofit organizations at the regional level and two at the state level. We conducted only one interview with a for-profit organization, which was at the state level. In some cases, organizations provided groups of two or three individuals to represent the organization during each interview. Thus, interviewee or respondent in this report usually refers to a single individual, but it also sometimes refers to a small group.

Table 2.2. Organizations Interviewed by Type and Level

<table>
<thead>
<tr>
<th></th>
<th>Local</th>
<th>State</th>
<th>Regional</th>
<th>National</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>25</td>
<td>31</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>14</td>
<td>19</td>
</tr>
<tr>
<td>For profit</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>39</td>
<td>51</td>
</tr>
</tbody>
</table>

**Analytic Process**

We entered all debrief notes into the team-oriented, cloud-based analytic software Dedoose. Our coding team then reviewed our preliminary analysis of our first 24 interviews and presented these preliminary findings to the ASPE/CDC project team. Our team also looked over debrief notes from the remaining 27 interviews and reexamined the interview protocol and debrief notes form. Following team discussion, we decided to create seven master codes to capture the scope of content that we intended to cover in our coding process. These are described in Table 2.3.

Using these master codes, the lead analyst coded the first ten debrief notes. In the process of doing so, the lead analyst also developed subcodes to capture more nuanced differences among themes and content types within each master code.

Next, two additional coders were trained on the master code and subcode definition list. These two coders then completed a Dedoose coding application test, in which they were given 30 previously coded excerpts from the debrief notes and asked to assign the correct code from a list. Kappa scores from this test ranged from 0.6 to 0.7, which is considered to be good agreement. The lead analyst reviewed the coding test results excerpt by excerpt to resolve any misunderstandings or inconsistencies in assigned codes with the two coders.
Table 2.3. Master Codes and Definitions

<table>
<thead>
<tr>
<th>Master Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities</td>
<td>This includes language that describes collaborative activities that organizations described in the service of MH goals. It can involve activities such as organizing public challenges or screening events, setting up shared databases to work more effectively with other clinicians, attending or convening meetings among major stakeholders, or any other MH collaborative activities.</td>
</tr>
<tr>
<td>Communication media</td>
<td>This pertains to discussions of media and processes used to communicate and collaborate with other MH partners. Thus, it can involve communication up the chain to MH federal partners or all the way down the chain to patients and those at risk for CVD (as well as everything in between).</td>
</tr>
<tr>
<td>Relationships</td>
<td>This refers to dialogue concerning how Million Hearts has affected relationships among organizations working on CVD initiatives. It also includes dialogue describing the nature of relationships in MH partnerships (e.g., whether such relationships tend to be multilevel or multisectoral) and the quality of relationships (e.g., Do they involve mutual trust? Are they top-down? Are relationships well integrated?).</td>
</tr>
<tr>
<td>Facilitators</td>
<td>This refers to language concerning dynamics that help MH relationships develop or become strengthened over time. It also includes language about dynamics or properties that help MH efforts overall to be successful and have a lasting impact.</td>
</tr>
<tr>
<td>Barriers/challenges</td>
<td>These are descriptions of obstructions to MH partnerships or the success of MH programs. This can include challenges that respondents feel they are surmounting or have workarounds for or those that respondents feel are insurmountable at present.</td>
</tr>
<tr>
<td>Success stories</td>
<td>These include language that either (a) responds specifically to interviewer questions about MH success stories or (b) describes what the respondent appears to think is an impactful, lasting effect of MH activities (i.e., this can be in other parts of the interview or other sections of the debrief notes besides the “success story” section).</td>
</tr>
<tr>
<td>Recommendations</td>
<td>These include language that explicitly makes a recommendation for a component, dynamic, or activity to continue, increase, or be implemented in future MH work.</td>
</tr>
</tbody>
</table>

Final codes were refined through the training process and as the coders practiced on sample text excerpts. Additionally, the coders used the memo feature in Dedoose to flag excerpts for which they felt they had no subcode to assign, for which they had questions, or that they wanted the lead coder to manually review. The lead analyst continued to spot-check all coded interviews throughout the coding process.

Dedoose provides a variety of mixed methods for coding output tables. We used these tables as coding progressed to examine whether certain codes were being over- or underused, whether codes were frequently used together (and therefore might be redundant), and whether certain codes could be merged, deleted, or sometimes split into additional subcodes. These output tables also allowed us to examine results and make group comparisons (for example, between federal government organizations and other types).

During the coding process, multiple codes and subcodes could be applied to a particular excerpt of text. Thus, codes and subcodes are not designed to be mutually exclusive. Similarly, different respondents had different opinions about each of these codes and subcodes. Some respondents had opinions that directly contradicted the perceptions of experiences of other respondents; this is more likely to occur in subcodes with lower overall frequencies.
PARTNER Social Network Analysis

Methods

For the SNA, we used a tool called PARTNER, which is a validated social network survey and analysis tool (Varda, 2017). It consists of an online survey that can be used to analyze how members of cross-sector networks are connected, how resources are exchanged, the levels of trust and perceived value that exist among network members, and how these attributes and the process of collaboration link to outcomes. PARTNER is different from other SNA tools because it includes both a validated 19-question survey and an analysis tool; that tool allows users to analyze data immediately because it does not require data cleaning or the creation of a network survey from scratch. For more information about PARTNER, see Varda (2017).

The PARTNER Analysis Options

Figure 2.1 identifies how the PARTNER tool visualizes networks in terms of strength and direction of relationship, partner value attributes, and partner trust. The graphic showing the MH network is in Chapter Five (Figure 5.1). Our analysis of the data focused on three key
attributes: (1) measures of network density (the number of connections reported between organizations), of degrees of centralization of the network around a few (or many, in a decentralized network) organizations, and of trust (measured as partners’ perceptions of whether other partners are reliable, in support of the network’s mission, and open to discussion); (2) individual network scores; and (3) value (measured as partners’ perceptions of whether other partners have mission congruence, contribute resources, and have a time commitment to the work). By using the tool, users are able to demonstrate to stakeholders, partners, evaluators, and funders how their collaborative activity has changed over time and illustrate the progress made in how community members and organizations participate.

Data Collection Methods

Bounding the Network

The Million Hearts network is not a bounded network; rather, it is a group of core federal and private-sector partners that participate in MH activities and initiatives. These range from more formal relationships in which one or more organizations in the network have a defined relationship related to their MH work (i.e., through funding or memoranda of understanding) to those that are more prospective in nature (i.e., in which the partners may only communicate about their MH activities now but later may develop formal partnerships). Thus, the first task in this analysis was to “bound” the MH network to determine which organizations to include in the SNA. This was required because we wanted to survey each organization identified as a network member (rather than take a sample from a population). To bound the MH network, we accessed the list we compiled previously for the interviews and added to that any partners that were mentioned by those interviewees. We clarified on this list how organizations would be identified and when an organization would be identified by departments within the organization (e.g., we identified three departments within the CDC to include). We also identified the person from that organization we believed could best answer the questions about the organization’s participation in the MH network. This list was reviewed by the project team. This resulted in a list of 61 organizations that we sought to include in the survey. This list was later modified to include only 58 of the original 61 organizations, after it was determined that three organizations included were not considered partners in the network.

Modifying the PARTNER Survey

The project team customized the default PARTNER survey to customize it for the MH context in order to appropriately answer the project’s research questions about MH member interactions, the content and quality of those interactions, perceptions of trust and value among members, and barriers and challenges related to participation. These modifications included altering some of the original 19 questions and adding several more based on the project
objectives, information learned from the environmental scan and interviews, and previous surveys developed by the research team on similar projects. The revised PARTNER survey was reviewed by the project team.

Administering the PARTNER Survey

The PARTNER survey was launched in November 2016. A letter introducing the project and requesting participation in the survey was emailed to the bounded list by the MH leadership team. Following the introduction letter, the PARTNER team sent an email to invite all members identified in the network to take the survey. Each respondent was given a personalized link. Multiple reminders were sent to nonrespondents by email and phone. After we exhausted all options for further reminders, we closed the survey and began analysis. The final response rate was 74 percent. While not all organizations answered the survey, the data do consist of information on all 58 organizations, because every organization was identified by at least one other organization participating in the survey as one of the partners with which they interact in Million Hearts. Thus, there are data representing at least the perceptions about each organization we attempted to survey.

Analyzing Data

Descriptive Analysis of the Million Hearts Network

Data were analyzed using the analysis framework built into the PARTNER tool. This method involves compiling descriptive analyses of the network, including information on the structure of the network, number and types of partnerships, quality and content of partnerships, and outcomes related to partnerships.

Comparing Million Hearts to Other Networks

In addition to the descriptive analysis, we conducted a comparative analysis of the MH network in relation to other networks that shared similar features. This is possible because the PARTNER data set contains information from all the prior users and previous SNAs conducted with the tool. As of January 2017, the PARTNER team had cleaned and deidentified a dataset of approximately 7,500 networks, encompassing 13,699 organizations and 100,000 dyads (interactions between two organizations in a network). Points of comparison include structural measures, such as centrality (key player) positions that can tell us about which types of organizations play various roles in the network; whole network indices, such as centralization, density, or trust; average scores for trust and value; perception of trust and value among partners in the network; and other constructs and measures. As with all social network data, comparisons can be made at the organizational, dyad, or whole network level.

To provide some context to the descriptive findings, we used our large database of similar cross-sector interorganizational networks to identify ways in which the MH network is similar to, and varies from, other types of networks. From this database, we identified three groups of
networks for comparison, narrowing from the 533 public-health-related networks available in the database. From that group, we extracted three specific types of networks to create the following three groups:

- **Chronic disease prevention (CDP) networks.** From the larger database, we pulled 46 networks that have a similar broad focus in the area of CDP. To find these 46 similar networks, we used the following search terms: cancer, heart disease, diabetes, stroke, arthritis, obesity, healthy, food, active, living, fit, and eating. If a network had any of these search terms in its collaborative name, its survey questions, or its survey response options and was verified by a closer look at each network individually, it was included as part of the chronic disease prevention data.

- **Similar-size networks.** This includes all networks that were public health focused and that had a similar number of members (between 60 and 70). This list contained 18 comparable networks.

- **National-level networks.** Finally, we used data from two national-level networks that are similar to Million Hearts in that they include network members that represent national organizations, including those from the public and nonprofit sector. While these networks varied in size and focus areas, they provided a unique comparison group in our examination of the ways in which other networks that work with national-level organizations structure their network, the ways in which these network members interact, and the kinds of activities and contributions they participate in together.

We discuss the results generated by these three methods in the following three chapters.
3. Assessing How Million Hearts Partners Are Connected and the Activities They Are Engaged in to Achieve Cardiovascular Disease Prevention Goals

Introduction

One of the primary aims of this research was to assess how the various organizations that compose Million Hearts are connected, identify the approaches they are taking to address CVD prevention in their communities, and assess how they interact to achieve these goals. Data from all three research approaches inform these questions.

In this chapter, we focus first on defining the composition of the MH initiative and summarizing our findings from the environmental scan; then, we outline the major goals MH partners are trying to achieve and the activities they have adopted to achieve these goals. We have weaved in information from both the environmental scan and the key informant interviews to provide a more nuanced account of these activities from the perspective of the national partners. The interviews and SNA also provide an understanding of how MH partners connect across the local, state, and national levels.

Composition of the Million Hearts Initiative

Convening a cross-sector group of federal and private agencies to address chronic disease is an innovative and complex task. Our environmental scan highlights that MH partnerships involve participation from various federal agencies and national-level stakeholders, such as the American Heart Association (AHA), as well as local health departments, federally qualified health centers (FQHCs), health systems, hospitals, and community clinics. Health professionals (e.g., physicians, nurses, and pharmacists), university representatives (e.g., from medical, pharmacy, nursing, and public health schools), and quality improvement (QI) organizations are also key partners in many MH collaborations.

While much of the research reported here addresses the national network of MH partnerships, both the environmental scan and the interviews highlight that MH is also composed of a large number of local partnerships addressing CVD prevention activities in their own communities rather than centrally determined, national projects. For example, about half of the documents we reviewed for the environmental scan described partnerships involving only local or local and state partners (Table 3.1).
Table 3.1. Counts of All Variations of Partnership Levels

<table>
<thead>
<tr>
<th>Partnership Level</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>National (only)</td>
<td>7</td>
</tr>
<tr>
<td>State (only)</td>
<td>14</td>
</tr>
<tr>
<td>Local (only)</td>
<td>13</td>
</tr>
<tr>
<td>National/state/local</td>
<td>5</td>
</tr>
<tr>
<td>National/state</td>
<td>9</td>
</tr>
<tr>
<td>National/local</td>
<td>2</td>
</tr>
<tr>
<td>State/local</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
</tr>
</tbody>
</table>

NOTE: Based on 74 partners identified in environmental scan.
SOURCE: Analysis of environmental scan data.

Further, when all variations of partnerships were grouped into three categories of geographic levels (see Table 3.2), partnerships with state-level partners (52 out of 74) and local-level partners (44 out of 74) were found to be more common than national-level ones (23 out of 74). A full list of MH partnerships identified by the scan is contained in Appendix Two.

Table 3.2. Counts of National, State, and Local Partnership

<table>
<thead>
<tr>
<th>Partnership by Geographic Level</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>National (any national partner involved)</td>
<td>23</td>
</tr>
<tr>
<td>State (any state partner involved)</td>
<td>52</td>
</tr>
<tr>
<td>Local (any local partner involved)</td>
<td>44</td>
</tr>
</tbody>
</table>

NOTE: The Ns do not sum to the total number of partnerships examined in this environmental scan, since all variations of partnerships, regardless of whether they included multiple levels of partners, were counted. For example, a partnership that was at the national and state levels was counted twice and marked in both the national and state columns.
SOURCE: Analysis of environmental scan data.

The type of stakeholders participating in each partnership often corresponded to the intended reach of each activity. A number of federal and national nongovernmental organizations were involved in national-level efforts, while many state- and local-level partners were involved in activities that aligned with their organizations’ geographic scope of work. For instance, several federal agencies and national nongovernmental organizations, including the Agency for Healthcare Research and Quality, the National Association of Chronic Disease Directors, the CDC, and the CMS, collaborated to produce an informational document on self-measured blood pressure monitoring to be used by public health practitioners around the country. While some partnerships only included stakeholders from the same geographic level, other partnerships
included a mix of stakeholder types. For example, the Association of State and Territorial Health Officials’ (ASTHO’s) multipronged approach to reduce CVD included partners in the federal government, national nonprofits, and state health departments (Jarris et al., 2014). The majority of partnerships with both national- and state-level partners engaged in activities at the state level, while many partnerships that focused on local initiatives involved partners at both the local and state levels. In state- and local-level partnerships, a state health department was almost always involved. For example, through an alliance between the Whitney M. Young, Jr., Health Center, the New York State Department of Health, and other state and local partners, a clinical pathway was developed to identify and manage patients with hypertension at the FQHC.

Goals and Activities

In addition to identifying which organizations compose Million Hearts, the research was designed to identify what goals MH partners were trying to achieve and the activities they developed to address their goals. The environmental scan and key informant interviews revealed that MH partnerships tended to focus on one or more of the following goals: (1) increasing awareness of the ABCS, hypertension, CVD, or other MH foci; (2) implementing reporting measures and practices on the ABCS; (3) training medical care providers (e.g., nurses, public health nurses, pharmacists, or medical practitioners) in the screening and prevention of CVD and hypertension; and (4) increasing use of tools aligned with MH.

The environmental scan showed that the audiences, or target populations, impacted by each partnership’s activities varied depending on the setting in which the activity was implemented, as well as the focus of the activity. A large majority of partnerships in the environmental scan targeted health care professionals (e.g., medical providers, nurses, public health practitioners, or pharmacists), who received tools, education on the ABCS and best practices, and support to implement programs and interventions emphasizing areas such as team-based care, screening, and risk management. In a majority of documents, patients in these health settings, who typically had hypertension or other risk factors, were also targeted through interventions that provided care, information, and other services. Almost 40 percent of MH partners also aimed to provide the general public with CVD prevention information. These goals and sample activities are described in more detail here.

1. Increasing Awareness of the ABCS, Hypertension, Cardiovascular Disease, or Other Million Hearts Foci

In almost all the documents, partnerships described their activities as focusing on increasing awareness of issues highlighted in MH (hypertension, CVD, etc.). Half the documents focused on raising the awareness of the general public, while about 20 percent concentrated on educating medical professionals. For example, the WomenHeart network used materials developed by the Preventive Cardiovascular Nurses Association to educate women and families on hypertension
through peer mentors (Benjamin, 2012), and the Wisconsin Heart Disease and Stroke Alliance held meetings to share clinical best practices and resources connected to disease prevention and management among medical providers (MetaStar, 2016).

2. Implementing Reporting Measures and Practices for the ABCS

The majority of partnerships also shared a goal of aligning with MH data collection and reporting policies. For example, the Carolinas Center for Medical Excellence and the CMS worked together to encourage the meaningful use of electronic health records (EHRs) and the reporting of the ABCS in the Physician Quality Reporting System in North Carolina (Simpson, Massing, and Simpson, 2012).

3. Training Medical Care Providers in Screening and Prevention of Cardiovascular Disease and Hypertension

About half of the documents we reviewed identified the training of medical care providers as a goal. This type of training focused on screening patients for high blood pressure, identifying and following up with at-risk patients, reporting on the ABCS, working with community partners such as pharmacists and public health nurses to provide team-based care, and promoting practices such as self-monitoring of blood pressure. For instance, the American Academy of Nurse Practitioners sponsored the Cardiovascular Interest Group as part of its annual conference, during which 50 nurse practitioners shared success stories and best practices from their specific communities and held a brainstorming session on how to share screening and prevention tools and further support progress toward the MH goals (Davis and Wright, 2012).

4. Increasing Use of Tools Aligned with Million Hearts

Promoting the increased use of tools related to Million Hearts was mentioned in 30 percent of documents. These tools typically focus on helping medical professionals address the goals of MH by making it easier to screen for health conditions such as high blood pressure, providing advice on proper treatment and medication for these health conditions, and simplifying the reporting and monitoring of a patient’s ABCS. The most frequently mentioned tool was the AHA’s Heart360; however, many tools have been designed by partners to help progress toward MH’s overall goals. One such tool is Heart Health Mobile, a mobile device application that was used by members of the Wisconsin Heart Disease and Stroke Alliance to calculate risk factors of patients for high blood pressure, stroke, high cholesterol, and heart attack (MetaStar, 2016).

The 51 key informant interviews provided more specifics on the tools MH partners developed to support these activities. Similar to findings from the environmental scan, many respondents (32 out of 51) described sharing or collaboratively producing educational materials, intervention packages, and standardized tools for diagnosis. More than one-third (19 out of 51)
of interviewees said that their organizations convened meetings, organized collaborative initiatives, or conducted training for clinicians or other practitioners (e.g., training in how to share data with other organizations). And almost one-third of respondents (16 out of 51) also described being involved in public screening, health fairs, or other public education activities (although most of these respondents were nonfederal partners). Another third mentioned providing or receiving funds for MH purposes.

Disseminating Million Hearts Information and Implementing Million Hearts Activities Through Networks

In addition to the four general goals just mentioned, about 20 percent of the documents we reviewed described the partnership in question as actively seeking to develop a network approach to support these goals. Some networks worked actively to support their partnership by providing resources to strengthen the capacity of partners to participate. They did this primarily by sharing resources, including educational materials, data, tools, referral sheets, and innovative ideas on best practices. Partnerships tended to share these resources through different avenues, such as webinars, email distribution, in-person meetings, social media, and conferences. These resources support the goals of MH by operationalizing how different agencies can align their promotion, measurement, and reporting of the ABCS. For example, the American College of Cardiology uses multiple media outlets to spread MH announcements, tools, and educational materials. Furthermore, the college manages a registry that contains data on the ABCS from approximately 3 million unique patients nationwide, and this tool is used to communicate shared performance improvement goals to relevant provider communities. This sharing of resources was found in each article abstracted. A small number of documents mentioned that a goal was to influence payers or policy.

The SNA provided even more depth to these findings. The most often identified examples of how partners leveraged their membership in the national network included exchanging information or SMEs, developing tools and resources to share with other MH partners, implementing new CVD prevention programs or strategies (including disseminating information and tools and engaging in advocacy), providing training and technical assistance for implementing new CVD standards of care or practice guidelines, conducting research, developing standards of care or practice guides, and funding CVD research or programs.

The SNA also allowed us to identify how integrated partners are in implementing activities, in addition to identifying their specific approaches. At the national level, 304 respondents were asked to describe the nature of the activities they engaged in with their partners. Such relationships can be classified as one of four levels of activities, in increasing levels of complexity, as shown in Table 3.3.
Table 3.3. Nature of Activities That Social Network Analysis Organizations Engaged in at National Level

<table>
<thead>
<tr>
<th>Level of Activities</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Awareness</td>
<td>This involves understanding what the organization’s role is in the system.</td>
<td>You understand the services offered, resources available, and mission or goals.</td>
</tr>
<tr>
<td>2. Cooperative activities</td>
<td>This involves exchanging information, attending meetings such as the MH Federal Assembly or the MH Leadership Roundtable together, and informing other programs of available services.</td>
<td>You organization attends monthly MH calls with this organization.</td>
</tr>
<tr>
<td>3. Coordinated activities</td>
<td>This includes cooperative activities, in addition to the exchange of resources or service delivery and the coordination of planning to implement things such as client referrals, data sharing, and training together.</td>
<td>Your organization has coordinated developing standards of care together.</td>
</tr>
<tr>
<td>4. Integrated activities</td>
<td>In addition to cooperative and coordinated activities, this includes shared funding, joint program development, combined services, shared accountability, and shared decision making.</td>
<td>A formal program with funding exists between your organization and this organization.</td>
</tr>
</tbody>
</table>

Of 304 relationships described in the SNA analysis, 100 indicated that they only had awareness of one another (level 1), 119 indicated that they had only cooperative activity connections (level 2), 46 indicated that they only had coordinated activity connections (level 3), and 40 indicated they had integrated activity connections (level 4) with one another. Awareness and cooperative ties require the lowest level of resources in a network. The Million Hearts network ties at these levels make up 72 percent of all ties, indicating that partners tend to focus on low-resource relationships.

Relative to these findings, the environmental scan identified a greater emphasis on public education than on participation in funding of MH activities as either a primary funder or recipient. Conversely, academic publishing, press publications or interviews, and incorporation of changes to the built environment (e.g., by providing more walking paths or providing healthy food options to positively affect the MH target population) were only mentioned in the interviews and not frequently.

The environmental scan revealed some information about common ways partners disseminated tools and resources to other partners or communities for use in CVD prevention efforts. Although relatively few documents talked about each of these methods, the most often mentioned strategies were engaging in peer-to-peer networking and holding large meetings or symposia. For example, an MH case study in Maryland described a one-day symposium that “aimed to raise awareness about the Maryland Million Hearts Initiative, engage new and existing partners, and highlight best practices and resources for implementing evidence-based strategies.
to achieve excellence in the ABCS in various community and healthcare settings” (ASTHO, 2013, p. 4). Other less often mentioned activities included

- holding one or more webinars
- messaging through social media (Twitter, Facebook, etc.)
- creating a new website with MH information or resources and tools
- sending email announcements to existing contacts
- creating a new network of practitioners and policymakers through the web or another platform.

Summary

Through all three research methods, we identified many ways in which organizations have built local-level networks of partners to implement MH priorities and activities, and we found that the bulk of the MH partnerships and activities we identified occurred at the local level and often do not have a direct association with organizations involved in the core national MH partnership. All are clearly inspired by the national partnership and its goals, but many develop without direct assistance from national partners. Nevertheless, the national partnership is developing resources (information, tools, branding, etc.) that may be used to support the work of these local initiatives. This indicates that the goal of Million Hearts to bring a group of diverse stakeholders together to address issues of CVD has been achieved at the national level. However, nearly three-quarters of the relationships between national MH partners focus on awareness or cooperative activities. This could indicate that there are untapped opportunities to leverage the strengths of MH partners toward more projects of greater scale, depth, or impact.
4. Identifying What Is Working with the Million Hearts Approach and the Facilitators of and Barriers to These Successes

Introduction

Another major aim of this research was to identify what is working with the MH approach, including the specific facilitators of and barriers to the successful implementation of MH activities. Several points of data from our mixed-methods approach help answer this question. First, the documents we reviewed in the environmental scan pointed to several themes about what outcomes may have been achieved through local MH activities. In addition, we asked about various aspects of Million Hearts that are working for participants—success stories—in both the key informant interviews and the SNA. We also examined through the SNA another way of assessing MH impact: defining how participation in MH changed partners’ approaches to CVD prevention. Later in this chapter, we focus on the most often mentioned barriers to and facilitators of achieving these goals.

Key Themes Regarding Outcomes from the Environmental Scan

Several documents in the environmental scan highlighted the impact of MH partnerships on cardiovascular health at the local, state, and national levels. The following outcomes were reported as resulting from MH partnership activities (e.g., QI programs, public awareness campaigns, or educational interventions). However, none are drawn from formal evaluations, so caution should be taken in interpreting the results.

Increased Hypertension Control

Several MH partnerships stated that increased hypertension control was a primary outcome of their work. For example, the Healthy Hearts for Marylanders is a collaboration between the Maryland Department of Health and Mental Hygiene and the Mid-Atlantic Association of Community Health Centers. These partners worked with four FQHCs across the state to improve performance on multiple cardiovascular health QI measures. As an outcome of this partnership, participating FQHCs reported an increase in hypertension control (defined as BP<130/80) from 17 percent at baseline to 44 percent at the conclusion of the project (ASTHO, 2014a).

Improved Processes for Cardiovascular Care

One of the main aims of Million Hearts is to prevent heart attacks and strokes by improving access to effective care. Several MH partnerships identified improved processes for cardiovascular care as an outcome of their participation in MH. This included strengthening
processes for linkage to care, improving workflows within clinics and hospitals, and increasing effective communication between workers within a health care system. For example, the MH Delaware Coalition partnered with the Quality Insights of Delaware (QIDE) Regional Extension Center to develop a quality measures portal and determine areas for improvement in cardiovascular care. Through this partnership, QIDE helped clinics integrate workflow adjustments and improve care processes, thus increasing offers of smoking cessation counseling, reducing rates of loss at follow-up, increasing monitoring of patient prescriptions, and increasing patient engagement. According to the Office of the National Coordinator for Health Information Technology (2016), performance improved on aspirin therapy by 21.6 percent and blood pressure control by 54.1 percent among the 15 practices that participated in QIDE.

**Increased Cardiovascular Health Knowledge and Awareness**

Several MH partnerships highlighted increased cardiovascular health knowledge and awareness as outcomes of their work. Partners described accomplishing this through structured educational activities. For example, the Ohio State University College of Pharmacy, in partnership with the Helping Hands Health and Wellness Center in Columbus, Ohio, utilized the “Team Up, Pressure Down” MH educational program to raise awareness of, and encourage dialogue around, cardiovascular health among pharmacists and their patients. Some documents also mentioned how partnerships themselves increased awareness of cardiovascular health issues, even without formally implemented educational programs. For instance, ASTHO reported that a hypertension management collaboration between the New York State Department of Health and an FQHC heightened recognition among staff of the importance of cardiovascular health as a partnership outcome. In total, staff identified 14 patients with undiagnosed hypertension, and 12 patients reported increased awareness about self-managing their blood pressure (ASTHO, 2014b).

**Success Stories from the Key Informant Interviews and from the Social Network Analysis**

During the interviews, we asked specifically for respondents’ perceptions of what they felt were notable MH success stories. Their responses add depth to some of the outcomes reported in the environmental scan. For example, with respect to improved processes of care, about 37 percent (19 out of 51) of respondents described success stories having to do with expanded or improved clinical screening and early clinical treatment intervention for CVD, and 27 percent (14 out of 51) described success stories involving developing and disseminating common standards and shared protocols for screening, diagnosis, treatment, and other CVD-related activities (i.e., standardization of prevention and care to accepted best practices). Another 14 percent (7 out of 51) of respondents described how Million Hearts had particular success in creating efficiencies within existing processes for tracking, screening, and treating CVD.
About 25 percent (13 out of 51) of the respondents described how MH success has centered on increasing awareness of CVD risk and the importance of screening in the clinical and public health communities and the U.S. population in general. Along these lines, 4 respondents out of 51 indicated that they felt MH had helped achieve measurable reductions in CVD-related risk behaviors in the U.S. population.

The success stories told by respondents also highlighted other potential outcomes achieved by MH. About 20 percent (11 out of 51) of respondents described MH as having particular success in advancing a population health approach to CVD. For example, one respondent from a national nonprofit organization described the following:

At a health system level, what’s been great is the move towards population-based care. There are health systems now that know their hypertension prevalence in their population that they wouldn’t have known about five years ago. So there are successes at the national level all the way down to where they want to make a direct impact.

In addition, 24 percent of respondents indicated that they thought MH had its greatest impact by creating connections among practitioners, policymakers, and even CVD patients, which in turn created a greater sense of shared experience, shared purpose, and shared responsibility. One local government respondent described how the organization’s MH partnerships have “gone through the fire and back . . . . The fact that we’ve been through a lot and have had very difficult conversations, yet we’re still there—it’s a true testament to what can be accomplished with partners.”

To better understand the impact of MH on partner organizations’ CVD-related work, partners were asked two questions. Many partners stated that MH has played a strong role in their CVD work. About 40 percent indicated that it has played a larger role (indicated as “a great deal”) in their organization’s CVD work, and another 33 percent said it had a “fair amount” of influence. When asked specifically if MH has been integrated into the organization’s CVD work, half of respondents said that their work has been strengthened by Million Hearts, and just under half said that they use the MH branding to promote their work.

A majority of respondents in the SNA agreed that participation in MH helped them to achieve their goals and that the work of their agency had been strengthened by MH. When asked about the top five most successful strategies within MH, the responses with the most consensus included disseminating information and convening partners. Two of the most frequent responses to the question about what works best about MH were its experienced, collaborative, and supportive leadership, branding, and messaging and its being affiliated with the CDC; these answers suggest that partners believe MH has strong leadership and that this leadership plays a significant role in the initiative’s success.
How Participating in Million Hearts Changed Partner Approaches to Cardiovascular Disease Prevention

This research also had a primary aim of defining how participation in MH changed partners’ approaches to CVD prevention. This is also another way of assessing the impact of MH. The environmental scan identified no information on specific changes in individual organizations’ or partners’ CVD prevention activities. In addition, there is a lack of information on the activities that these agencies engaged in before MH. This makes it difficult to assess how their CVD prevention activities have changed as a result of participation in Million Hearts. Although some documents comment on how partners have developed new activities to address the goals of MH, they do not cite specific examples. It is possible that the goals of organizations and partnerships were reframed to match MH, but no evidence for this was presented by partners.

However, the SNA did specifically ask about whether partners had experienced changes to any of their activities, processes, or resources as a result of participation in MH. The most often identified changes included working to reduce heart-related health disparities, raising awareness of the ABCS, communicating between sectors and agencies, sharing resources among stakeholders, and sharing knowledge of CVD prevention among organizational stakeholders (as shaded in Table 4.1).

<table>
<thead>
<tr>
<th>Response Options</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working to reduce heart-related health disparities</td>
<td>19</td>
</tr>
<tr>
<td>Raising awareness of the ABCS</td>
<td>19</td>
</tr>
<tr>
<td>Communicating between sectors and agencies</td>
<td>19</td>
</tr>
<tr>
<td>Sharing resources among stakeholders</td>
<td>18</td>
</tr>
<tr>
<td>Sharing knowledge of CVD prevention among stakeholders</td>
<td>15</td>
</tr>
<tr>
<td>Developing new CVD prevention tools and infographics</td>
<td>13</td>
</tr>
<tr>
<td>Aligning CVD prevention activities with the ABCS</td>
<td>12</td>
</tr>
<tr>
<td>Developing programs around CVD</td>
<td>11</td>
</tr>
<tr>
<td>Increasing CVD knowledge and awareness</td>
<td>11</td>
</tr>
<tr>
<td>Working to inform policy, law, or regulation changes to support heart health</td>
<td>9</td>
</tr>
</tbody>
</table>

SOURCE: Analysis of social network data.

MH’s impact on relationships with partners was identified in the SNA. Out of the 304 partnerships reported, 56 percent were directly attributed to MH, either as a new partnership that was developed specifically because of participation in MH (44 relationships) or as an
existing relationship that has been improved through working with Million Hearts (125 relationships).

The key informant interviews provided depth to these results about relationships. Many respondents enthusiastically described how MH has helped them make new connections, deepen existing connections, and both amplify and broaden their impact on CVD risk reduction and improvements in clinical practices. More than one-third of respondents (18 out of 51) described forming wholly new relationships as a result of engaging in MH activities, and one-quarter (13 out of 51) described participating in entirely new networks, such as research- or practice-focused collaborative groups composed of many different types of partners, including enduring infrastructure and management teams that ensured that these networks were maintained over time. And a little less than 20 percent (9 out of 51) of respondents described how they collaborated with MH partners with whom they already had preexisting relationships; however, as a result of MH activities, these relationships grew and deepened. For example, one respondent from a national nonprofit organization stated, “[MH] allowed our partnership to expand from one critical issue that we were tackling to two. And that was a direct result of our commitment to and participation in Million Hearts.” Only two respondents described the other MH organizations with which they were partnered primarily as “allies”—that is, other organizations working toward the same goal but not necessarily in direct collaboration.

Facilitators and Barriers

Using all three methods, we attempted to identify which facilitators and barriers most influenced the processes by which partners formed relationships and reached their goals. These are summarized here.

Facilitators

Across research methods, we identified common facilitators of the successful implementation of MH activities and development of strong partnerships. Chief among these was the alignment of goals among partners, which was cited as being particularly helpful for developing strong partnerships and achieving the goals of their MH activities. Another important factor that was cited across research approaches was gaining the buy-in of the leadership of participating organizations, which is necessary for supporting the longer-term participation of a partner. Other common facilitators include good communication between partners, diverse partner sets, trust, and funding. One factor that was cited specifically as a facilitator of a network’s ability to achieve positive CVD prevention outcomes was the ability of a partnership to recognize the unique resources members can contribute and then dedicate specific efforts to designing approaches that leverage these assets.

Several crosscutting themes arose in the key informant interviews and SNA that provide more nuance to the understanding of these facilitators. First, respondents discussed the
importance of the clearly defined mission of Million Hearts. They appreciated the way that MH pushed a specific, focused set of goals for CVD risk reduction as something that motivated and enabled their collaborative MH work. Partners indicated that they thought that the MH brand was effective for connecting their work to the larger initiative and that those interactions with other network members played a significantly positive role in their organization’s CVD work. As one respondent described it,

[MH has] brought a lot of organizations together that don’t always talk . . . so that the physicians and the nurse practitioners and dieticians and whoever else, are all at the same table talking about how they can each impact heart health— that no one health profession owns it.

Second, leadership also featured heavily in both the interviews and the SNA. In particular, participants praised MH leadership within the federal government for being engaging, being involved, and helping to bring potential MH partners together, as well as for “flattening” the playing field and downplaying any potential hierarchy among organizations. Respondents also praised MH for creating a spirit of “friendly competition” and recognizing both outstanding MH efforts and smaller contributions to help motivate MH partners. These efforts were cited as helping to keep partners engaged.

**Barriers**

Although partners generally reported being satisfied with their involvement in the Million Hearts network, there were certain barriers to participating in MH or facilitating MH partnerships that consistently came to light. All three research methods revealed that a lack of direct funding for MH—compounded with already-stretched budgets and staff resources and competing priorities—has limited the ability of some organizations to engage in collaborative MH efforts. Further, getting the right partners to the table was an important barrier; conversely, having new partners (regardless of how appropriate the mix of partners is) can make it difficult to achieve goals if partners have a lack of experience on the issue being addressed or a limited history of working together and have different perspectives on CVD prevention.

In the interviews and SNA, MH partners also described a need to identify more clearly how they and other partners can implement new MH strategies at the local level, particularly with respect to identifying how the strategy of MH is distinct from existing strategies. Many also described their frustration with moving through bureaucratic processes and difficulties coordinating with partner organizations. National partners were also concerned about channeling information, data, and insights from the local level to state, regional, and national MH partners. Overall, challenges of priorities, perspectives, and coordination of resources such as time are prevalent in the minds of the MH network’s members.

Such barriers are not unique to Million Hearts; this kind of frustration is typical when bringing together a diverse group of partners.
Summary

We identified some evidence that MH partners are achieving CVD prevention and process improvement outcomes through MH. Million Hearts partners are working to strengthen their partnerships to achieve these goals. Respondents also reported that additional successes of MH are its approach to advancing a population health approach to CVD prevention and its focus on creating connections among various stakeholders, which, in turn, has created a greater sense of shared experience, purpose, and responsibility.

The interviews and SNA highlighted that a large majority of partners believe that MH played at least a fairly substantial role in their organizations’ CVD prevention work, and about half of the SNA participants said that their partnerships with other organizations were strengthened by it, which further helped them achieve their goals. In addition, MH participants also identified raising awareness of the ABCS, sharing resources among stakeholders, developing new programs, and communicating between sectors and agencies as their most important changed activities as a result of participation in MH.

The common facilitators of these successes included the alignment of goals among partners, the attainment of the buy-in of the leadership of participating organizations, good communication between partners, diverse partner sets, trust, the recognition and leveraging of the resources of other members, and funding. Commonly identified barriers included a lack of direct funding, difficulties with bringing partners to the table, a lack of experience among partners, and different perspectives on CVD prevention among partners. Further, there was some concern that more could be done to identify how to operationalize MH activities at the local level. While these barriers are not uncommon in network approaches, they are avenues that MH leadership may wish to address for future iterations of Million Hearts.
5. Assessing How Million Hearts Partners Interact to Work Toward Achieving Cardiovascular Disease Prevention Goals

Introduction

Another important research aim was to identify how MH partners interact to achieve their CVD prevention goals. To address this aim, we use all three methods to examine the specific details among partners of the MH network in a nuanced way. The environmental scan and key informant interviews emphasize the importance of partnerships, provide examples of those partnerships, and provide a general overview of what those partnerships look like in practice. The SNA allows us to look deeply at these partnerships and better understand the strengths, weaknesses, and patterns evident in the network, establishing a set of baseline measures that can be a reference for MH to look back at as it grows and evolves.

What We Know About Million Hearts Partner Interaction from Environmental Scan and Key Informant Interviews

The environmental scan and interviews provide a breadth of information and emphasize the importance of relationships; however, they were limited in providing specifics about the actual context, content, and quality of the interactions among members of the MH network. For example, only 8 of the 74 documents in the environmental scan mentioned how involved partners were with one another, with about half of those 8 documents describing highly integrated activities and half describing less integrated activities.

The interviews shed a little more light on these relationships. About one-quarter of the 51 respondents commented on how MH partners were highly integrated with each other and functioned effectively as a result. One-fifth of respondents indicated that they felt information flowed mostly from higher (i.e., federal) to lower (e.g., state or local) levels rather than from the bottom up. In contrast, only a few respondents described MH partnerships as highly reciprocal, that is, with efforts by MH partners, even at the lowest level, being rewarded and acknowledged by others in the MH community—whether through mention on a website (e.g., the MH badges that can appear on MH partner websites) or even just through passing mention on a conference call. Several respondents also described how MH partnerships were built on mutual trust, which increased both the functionality and the longevity of these relationships. Similarly, two respondents said that Million Hearts helped to level the playing field and decrease any potential hierarchy among partners.
What We Know About Million Hearts Partner Interaction from the Social Network Analysis

To get a more nuanced picture of the relationships among partners, we rely on the SNA, which provides findings that demonstrate the range of information, from the broad descriptions of partnerships generally to the details of how partners are connected, how strong these bonds are, and how integrated the network is as a mechanism for reaching goals. Convening a cross-sector group of federal and private agencies is an innovative, complex task. The MH network has a number of characteristics that are similar to other ongoing efforts to bring cross-sector partners together; however, it is also unique in some important ways. Here we use the results of the SNA to describe the structure of the network (the number and types of partners that are connected to one another) and the content and quality of those relationships.

**Structure of Million Hearts Network**

We find that the network is a diverse cross-sector network that has less activity than expected and no central hub. We discuss these findings in this section.

The Million Hearts Network Structure Is a Diverse Cross-Sector Network

The MH network has successfully brought together multiple partners from a variety of sectors. The stated mission of MH—to nurture and influence partnerships to promote cardiovascular health through a series of public-private partnerships—is demonstrated by the large number of federal and private-sector organizations (58) that are considered “partners” of the network. Collectively, 304 dyadic partnerships (defined as any two organizations and the relationship between them) were identified and described by the respondents. Figure 5.1 shows the 304 dyadic partnerships in terms of five partner group types, shown in the key. In the graphic, each colored circle represents one partner in the MH network. The black lines represent relationships between partners in the network, as indicated by respondents. A high number of lines indicates that a large number of partners claimed a relationship to that organization. The blue circle represents those organizations that make up the core of the network, with the organizations that are on the periphery of the network falling outside this circle. Those at the core have more connections to others, while those on the periphery have fewer connections. In this particular network, there was no strong pattern regarding which sector had more connections.

We identified the following proportions and groups among the 58 partners surveyed and shown in Figure 5.1:

- 34 percent (n = 20) were identified as federal public health research or regulation groups.
- 31 percent (n = 18) were private professional associations.
- 16 percent (n = 9) were labeled as private health plans, systems, or practices.
- 12 percent (n = 7) were from federal public health programs or services.
- 7 percent (n = 4) were identified as private groups that did not fall into the other categories.
The Million Hearts Network Has Less Activity Than Expected

While the diversity of the network is a strength, there is less activity than expected among the partners. Overall, only 15 percent of all possible connections among partners were reported. This measure represents the “density” of the network. The score is presented as a percentage to describe the proportion of connections that were reported in relation to all possible connections. In this case, the density score of 15 percent is very low, although similar to the scores of other similarly sized networks. What makes this density score stand out as particularly low is that it remains so even with a high response rate. Typically, a higher response rate will boost the likelihood of a higher density score because all of the actual connections are revealed. The combination of a high response rate (more unusual for a large network) and such a low density score shows the low number of connections among MH partners. This means there is a great deal of opportunity in the MH network to develop connections between participating organizations.

Recall from Chapter Two that PARTNER data allow us to compare the MH networks with three other types of networks: (1) CDP networks (n = 46); (2) similar-size networks (n = 18); and (3) national-level networks (n = 2). Compared to networks that have about the same number of partners (similar-size networks), the MH score (15 percent) is relatively similar (19 percent in the 18 other networks). However, other networks working on the same issues related to CDP have much higher density scores (52 percent), and other national networks made up of similar types of organizations have density scores of 41 percent (Table 5.1).
Table 5.1. Comparison of Density Scores Across Four Networks

<table>
<thead>
<tr>
<th>Network</th>
<th>Density Score (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Million Hearts</td>
<td>15</td>
</tr>
<tr>
<td>Similar-size networks (n = 18)</td>
<td>19</td>
</tr>
<tr>
<td>CDP networks (n = 46)</td>
<td>52</td>
</tr>
<tr>
<td>National networks (n = 2)</td>
<td>41</td>
</tr>
</tbody>
</table>

SOURCE: Social network analysis data.

More specifically, the average number of relationships per partner in the MH network was 5, although the range of partners any one organization identified was between 1 and 31 out of a possible 57 (because respondents cannot select their own organization as a partner).

The lower density score of the MH network can mean a few things. To create a more cohesive and active network of partners, it is necessary to attempt to build more connections among partners. However, no one density score is the “best”; rather, when the partners are sufficiently connected to achieve the network goals (e.g., information can be shared easily and quickly), then that is a sufficient number of connections. The low density score of the MH network means that there are many “missing” relationships between partners that could be fostered to build a denser network. However, rather than assume that higher levels of interaction are desired, it may be more appropriate to ask if the current levels and types of interactions in the network match the expected types of interactions and, further, if those are sufficient to meet the goals of the network.

The Million Hearts Network Has No Obvious Central Hub

An interesting characteristic of the MH network is its lack of an obvious central hub, which is reflected in a moderate centralization score (39 percent).

Centralization is a score that represents the degree to which the network is centralized around a few (or many, in a decentralized network) organizations. A low centralization score means that the network is very decentralized and that there is not an obvious hub of just a few organizations in the network. In contrast, a network in which a few (e.g., one to four) organizations are the most connected to the greatest number of other organizations would be a highly centralized network.

The MH centralization score is 39 percent. While there are six organizations in the network that have a larger number of connections than the others (25 or more connections), there are not one or two organizations that have the most relationships. We might have presumed that the CDC or CMS, as the designated leadership in the network, would have the highest number of connections to other partners. However, only two of the three CDC divisions in the network have 25 or more connections to others. Another interesting pattern in these relationships is that the 6 organizations that have the most connections to others are not connected to the same 25 other
organizations, and the relationships are more evenly spread out to different parts of the network. It is not unusual for a network that has been together for some time to be decentralized. This is often the case when many of the partners know each other and indicated that they have relationships when they responded to the survey. However, the MH network is unusual in that it both is decentralized and has a low density.

The MH network has a lower measure of centralization (39 percent) compared to other similar-size networks (62 percent) and other national networks (63 percent). The MH network does have a similar centralization score to other CDP networks (41 percent) (Table 5.2).

<table>
<thead>
<tr>
<th>Network</th>
<th>Centrality Score (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Million Hearts</td>
<td>39</td>
</tr>
<tr>
<td>Similar-size networks (n = 18)</td>
<td>62</td>
</tr>
<tr>
<td>CDP networks (n = 46)</td>
<td>41</td>
</tr>
<tr>
<td>National networks (n = 2)</td>
<td>63</td>
</tr>
</tbody>
</table>

SOURCE: Social network analysis data.

The network’s particular structure is not necessarily positive or negative. The fairly equal positioning of all the partners in the network (with no one partner holding most of the connections to others) can result in a balance among partners. This kind of balance can promote feelings of equalization, which can be a strength in a network; alternatively, an imbalance in structure can indicate a power imbalance that can discourage partners from staying involved.

To get a better understanding of what the network would look like if we removed the CMS or CDC (MH leadership) from the network, we did a sensitivity analysis. Specifically, we asked, “How is the network connected without the CDC?” or, in other words, “Is there a ‘network’ without one of the federal co-leads?” and “Are there other organizations that play the role of convener?” In this analysis, we found that the CDC, while well connected, did not serve as a “bridging organization,” as evidenced by the strong connectivity of the network when we removed their data from the network as part of a sensitivity analysis we conducted. Finally, when we looked at what kinds of activities partners engage in, we saw little change when the CDC or CMS was not a partner (Table 5.3).
Table 5.3. Outcomes Described That Partners Attribute to Building Relationships, With and Without the Centers for Disease Control and Prevention or the Centers for Medicare and Medicaid Services as a Partner

<table>
<thead>
<tr>
<th>Response Options</th>
<th>With CDC or CMS as a Partner (n = 247)</th>
<th>Without CDC or CMS as a Partner (n = 199)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exchanging information and subject matter expertise</td>
<td>77% (190)</td>
<td>78% (155)</td>
</tr>
<tr>
<td>Developing tools and resources to share with other MH partners</td>
<td>24% (59)</td>
<td>23% (46)</td>
</tr>
<tr>
<td>Implementing new CVD prevention programs or strategies, including disseminating</td>
<td>18% (44)</td>
<td>16% (32)</td>
</tr>
<tr>
<td>information and tools, engaging in advocacy or awareness initiatives, and providing care to patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing training and technical assistance for the implementation of new CVD</td>
<td>13% (32)</td>
<td>13% (26)</td>
</tr>
<tr>
<td>standards of care or practice guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conducting research and research-related activities, such as collecting or storing data on CVD prevention</td>
<td>9% (22)</td>
<td>6% (12)</td>
</tr>
<tr>
<td>Funding CVD research or programs</td>
<td>8% (20)</td>
<td>6% (12)</td>
</tr>
<tr>
<td>Developing standards of care or practice guidelines for CVD measurement and</td>
<td>7% (17)</td>
<td>7% (14)</td>
</tr>
<tr>
<td>reporting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SOURCE: Social network analysis data.

Content and Quality

In addition to the number of relationships among partners (that result in information about how those relationships are structured), the content and quality of the relationships is also of interest. The SNA allowed us to learn some nuanced details of what partners do together, the quality of those relationships, and their perceptions of their partners along trust and value dimensions. We find that Million Hearts is primarily an information-sharing network, engagement is positive, and there is a high level of trust and value among the partners. We discuss these findings in this section.

Million Hearts Is Primarily an Information-Sharing Network

Despite some evidence that partners are fully integrated in developing tools and resources for MH activities, descriptions of partner interactions in the SNA illustrated that the primary type of activity was “information sharing.” In fact, 77 percent of all interactions were reported as resulting in the “exchange of information and subject-matter expertise.” Additionally, respondents selected “disseminating information” as the most successful MH strategy (followed closely by convening strategic partnerships). This demonstrates the achievements of the MH network in building a connected group of federal and private-sector partners that are able to successfully share information on issues related to CVD.

While most members report that their activities primarily involved information sharing, they also indicated a strong willingness to contribute their own organizational resources to the work. From community connections to specific health expertise (and many other resources), members
expressed a willingness to contribute resources to the work and in a greater quantity than most other networks. Specifically, members expressed a willingness to contribute their leadership and facilitation expertise—resources in greater supply among these types of national partners. Leveraging these resources could advance the network from a primarily information-sharing network to one that integrates other types of resource sharing.

There Is Positive Engagement

Partners indicated that participation in the network was beneficial to their organization because the MH brand was effective and network membership played a significant role in the organization’s work. In open-ended comments, respondents stated that they enjoyed working with other MH partners and said that their organization was able to accomplish great work with MH.

There Are High Levels of Trust and Value Among Partners

Measuring trust and value is important, as it provides context on the ways that partners perceive each other in a network. Both trust and value measures in the MH network are high. Table 5.4 shows how they compare with the other networks; the comparisons are discussed next.

<table>
<thead>
<tr>
<th>Network</th>
<th>Trust Score (%)</th>
<th>Value Score (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Million Hearts</td>
<td>85.5</td>
<td>73.08</td>
</tr>
<tr>
<td>Similar-size networks (n = 18)</td>
<td>61</td>
<td>72</td>
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<tr>
<td>CDP networks (n = 46)</td>
<td>78</td>
<td>80</td>
</tr>
<tr>
<td>National networks (n = 2)</td>
<td>86</td>
<td>80</td>
</tr>
</tbody>
</table>

**SOURCE:** Social network analysis data.

Partners reported that they placed high levels of trust and value in other organizations, with federal agencies and private professional organizations ranked the most trusted and valued by others. **Trust** is measured on a scale that includes partners’ perceptions of whether other partners are reliable, whether they support the network’s mission, and whether they are open to discussion. Respondents rated each partner on these dimensions, using the following scale: not at all (1), a small amount (2), a fair amount (3), or a great deal (4). The scores of the MH network are as follows: reliability = 3.72; support of the network’s mission = 3.30; and openness to discussion = 3.24. A score below 3.00 is considered not good, because that indicates that respondents rated one another below a “fair amount” and closer to “a small amount” for that characteristic.

To compare the trust score to other networks, we converted the three individual scores into a percent (by adding all three scores and dividing by 12, the total possible score). The resulting
total (whole) network score for trust (86 percent) is higher than for networks of a similar size (61 percent) and other CDP networks (78 percent). It is the same as other national networks (86 percent).

**Value** is measured on a scale that includes partners’ perceptions of whether other partners have mission congruence, whether they contribute resources, and whether they have a time commitment to the work. Respondents rated each partner on these dimensions using the following scale: not at all (1), a small amount (2), a fair amount (3), or a great deal (4). The MH network’s scores are as follows: mission congruence = 2.98; contribution of resources = 2.76; and time commitment = 3.03. A score below 3.00 is considered not good, because that indicates that respondents rated one another below a “fair amount” and closer to “a small amount” for that characteristic.

Value scores are aggregated across all organizations to create one score that represents the whole network, similar to the trust score, by adding the three scores and dividing by 12. The total (whole) network score for value (73 percent) is lower than other CDP (80 percent) and national (80 percent) networks, and just slightly higher than it is for networks of a similar size (72 percent).

Members of Million Hearts have high perceptions of their partners across these dimensions of value. The most valued feature of the partnerships is the organizations’ level of involvement in the work. The lower perceptions of value (but only slightly below the others, with a score of 2.76) are perceptions of the level of resources that they believe others contribute to the work. This could mean that members of MH do not believe that their partners contribute resources to the extent that they could. Overall, these are good results for the network.

**Summary**

The MH network effectively enables a diverse, cross-sector group of federal and private-sector partners to share information about issues related to cardiovascular health. Participation in the network requires only minimal resources for partners; however, the return on trust and value among members is high. These results demonstrate that the network is meeting its current goals and intentions to create an information-sharing platform. The fact that these activities are reported with or without CDC or CMS leadership demonstrates an important quality: the network is not dependent on these organizations to achieve these goals. In the future, if the MH network leadership decides that the network should go beyond information sharing, there is a foundation that can be built on to achieve additional goals. It is an achievement to develop a diverse network of partners that trust and value one another while engaging in information-sharing activities. Morphing this network into other structures and to fulfill other purposes can be a strategic next step.
6. Conclusions and Suggestions Going Forward

Conclusions

The Million Hearts network has been successful in many ways, particularly in engaging a diverse group of public-private partners in collectively addressing issues related to CVD. There appears to be a great deal of activity at the local levels among members of the MH network, and a connected group of organizations that have convened around this common goal at the national level. As an information-sharing network, MH has succeeded in reaching this goal. It appears that maintaining the network can have some tangible benefits without a lot of additional resources or change.

Suggestions Going Forward

Going forward, given that the current goal to develop a network of partners to disseminate and share information on CVD has been met, there are still some suggestions that MH leadership may want to consider to strengthen the current level of commitment and activity from its membership. We do not mean to imply that implementation of these suggestions will necessarily increase network effectiveness. This causal connection between the activities and outcomes depends largely on how the MH leadership defines the goals of the network. If new goals are articulated, we offer some additional suggestions. The suggestions are listed in order of the complexity of implementation, with the least complex suggestions listed first.

1. Maintain Current Programming and Leverage Existing Activity and Resources

Interview respondents and SNA participants focused a lot of attention on potential programmatic revisions, but in some cases participants stated that they wanted to make sure that some elements of the program were maintained into the future. For example, a large number of participants wanted to retain the focus on specific MH goals (e.g., the ABCS) and the powerful focus on saving lives through CVD screening and prevention. Additional respondents praised Million Hearts for integrating clinical and community approaches to CVD health and indicated that this emphasis should continue in future MH efforts. Respondents also frequently praised MH for pushing a public health model of CVD prevention—a holistic strategy that incorporates community approaches and considers the social and cultural context of behaviors; however, some respondents criticized the MH approach as too focused on clinical indicators and clinical improvements. Finally, a few respondents praised MH’s efforts to reach out to the general public through social media and other venues and commented that they would like to see even more of this in future MH efforts.
In keeping a focus on these current activities, MH leadership may also want to explore in more detail what activities are occurring among partners who reported them and use those partnerships as examples of ways that other members might choose to interact. Specifically, MH leadership may want to develop a list of best practices for working collaboratively to achieve MH goals. This could shift the network from being one that primarily focuses on information sharing to being one that includes more specific CVD prevention activities, without asking for more commitment from all partners. Further, MH may want to consider developing the evidence base for these and other potential MH activities by sponsoring evaluations of different approaches or developing in-depth case studies of specific programs or elements of programs that others can learn from. This may not only help direct partners to promising practices but also help communicate the impact of Million Hearts to other potential participants and organizational leaders to increase their buy-in to MH approaches.

2. Maintain Current Activity, but Focus on Strengthening Current Levels of Commitment and Engagement Among Members

By all measures outlined in the previous chapters, the MH network has been successful in nurturing partnerships across sectors to promote cardiovascular health. However, within the current network, MH leadership may want to consider a few steps to strengthen the current level of commitment and activity from its membership.

Some suggestions for change mentioned by respondents focused on increasing engagement and communication among partners. For example, some suggested constructing forums for sharing success stories and promising practices to improve innovation and sharing tips and tricks for better prevention efforts. One suggestion was for the MH leadership to develop more templates or easier step-by-step processes for submitting deliverables to encourage sharing among MH partners and mutual learning and innovation.

Although MH uses a variety of dissemination strategies, including holding one or more webinars and using social media for messaging (Twitter, Facebook, etc.), participants sought additional approaches to engaging with one another, such as through face-to-face meetings and forums in lieu of virtual forms of collaboration among partners. MH can build on this and other recommendations to develop MH into a more activated learning network in which such meetings can be used to disseminate new knowledge developed by leadership and the lessons learned by network members. These engagements could include specific activities, such as holding a large meeting or symposium, creating a new network of practitioners and policymakers through the web or another platform, and engaging in peer-to-peer networking, train-the-trainer engagements, or other direct disseminations of knowledge and tools.

Further, according to the results of our research, the national partnership is good at information sharing, but it may want to consider investing in technical assistance to encourage the adoption of the factors that support strong partnerships at more local levels. For example, providing training in communication among partners, educating partners on aligning goals,
identifying funding sources, and providing specific technical assistance on finding and engaging additional partners may all be useful to MH partnerships.

3. **Reevaluate Current Activities, Focusing on Some Activities Suggested by Partners**

   Overall, MH partners were very satisfied with the benefits of participating in the network, and they cited high-quality leadership and active learning through information exchange as the primary reasons. However, partners also identified a number of potential areas for improvement; some of these suggestions came directly from participants in the SNA and key informant interviews.

   Several respondents commented that they would like to see MH pay closer attention to measuring its impact and the impact of its partner organizations (e.g., requiring MH partners to report progress toward their goals or implementing epidemiologic studies to estimate reductions in CVD attributable to MH efforts). Also, several other suggestions focused specifically on interactions between MH members. These included diversifying the types of partners in the MH community, specifically by increasing the involvement of private (for-profit) organizations and linking with more university partners. In addition, a relatively large number of respondents suggested improving coordination in future MH efforts. Related suggestions focused on the continued need to emphasize and reward innovation at the clinical and community levels.

   In addition, some respondents wanted to see increased levels of resources and data. For example, a few respondents suggested that they thought the MH emphasis on data sharing—as well as sharing protocols and other information—should be increased in future MH efforts. In another example (as part of the SNA), MH partners rated resource contribution lower than the other two value dimensions and slightly below the threshold for a “good” score (as noted in the previous chapter). But members also reported a very high number of resources they are willing to contribute.

4. **Review Purpose of Million Hearts and Consider Clarifying Goals, Revising Member Expectations, or Changing Governance**

   **Consider Clarifying Goals**

   Partners listed a lack of clarity on how the strategy of Million Hearts is distinct from existing strategies and a lack of understanding of how to “operationalize” MH projects as two of the biggest barriers to implementing MH in their organizations. One area of some disagreement among partners is the amount of focus that should be placed on clinical versus community approaches. MH leadership should consider clarifying the goals for MH partners and make it easier for leadership to assess progress toward these goals.
Consider Revising Member Expectations

Million Hearts leadership should determine expectations about the levels of interaction between partners. Given that most of the outcomes reported by the respondents are related to information sharing and dissemination, the current level of interaction may be appropriate. However, MH leadership should consider whether the current levels and types of interactions in the network are as expected and, further, whether those are sufficient to meet the goals of the network. Across our three research methods, partners stated that MH had created opportunities for developing new relationships and deepening others and that this emphasis on relationship development was critical to the successes they had observed. If deepening these ties is important to MH, then this can be partially accomplished by incentivizing relationships, such as by sponsoring joint activities and conveying communication and network support strategies. The barriers mentioned related to the challenges of coordinating partners’ priorities, perspectives, and resources are issues that could be addressed in this kind of activity.

Consider Changing Governance and Communication

Currently, the MH network is highly decentralized, meaning that no one organization has emerged as the obvious “leader” of the network. As such, MH could explore options for establishing a more intentional leadership style in the MH network. Specifically, a more definitive and adopted role of MH leadership as the network facilitator (or backbone), coupled with a strategic governance structure (dictating who is responsible for what and how decisions are made), could help shift the structure of the network in a way that may lead to new and innovative opportunities. A more intentional leadership approach does not necessarily mean a more centralized network structure; rather, it means that a shared leadership approach led by MH could result in a range of different types of structures. This could evolve and shift over time.

Leadership may want to consider engaging members of the network in various leadership roles to facilitate and govern the network, with those positions rotating to encourage diverse representation in leadership (e.g., the CDC or CMS does not have to be the backbone—leadership from within the network may be considered as well). The SNA indicated that several federal and private-sector organizations do serve as bridging organizations in the network, which could be leveraged to engage more of the peripheral (less connected) members of the network.

5. Develop Diversified Funding Strategies to Support Million Hearts Work

Although most comments about funding focused on the need for funding to support greater participation in Million Hearts, some comments suggested that the lack of funding provides an innovative space to develop relationships and different approaches to CVD prevention. It is possible that MH could facilitate simple, diversified funding strategies, such as providing small, one-time funding opportunities to focus on a single policy or program issue or providing technical assistance funding. Or, by supporting the development of tools or information that partners across levels can use in their CVD work, the leadership could maximize its investments.
6. Adopt Other Strategies for Sustainability Suggested by Partners

Funding was not the only suggested strategy for sustainability by the partners. Other resources identified that would help MH achieve long-term sustainability include additional support from leadership to partners, easier platforms for national reporting, efforts toward better alignment of payment mechanisms, more focus on population and clinical interventions, and the building of partnerships with organizations dedicated to specific populations. In terms of what would support partners’ involvement in MH, a number of additional resources were mentioned. These include support and engagement with leadership, committed staff time for involvement in MH, and specific guidance from Million Hearts on implementing strategies at the local level. A theme throughout the report was the expressed commitment of members to contribute resources to the network, specifically in the areas of leadership and facilitation, combined with a perception that members are not contributing available resources to the network. This appears to be a missed opportunity for leadership to leverage the resources members have expressed a willingness to contribute. Leveraging these member-contributed resources can be an additional strategy for sustained support of the network.
# Appendix 1: Million Hearts Partners Identified in the Environmental Scan by Geographic Level

## Federal and Other National Partners

<table>
<thead>
<tr>
<th>Agency/Association</th>
<th>Federal and National Partners</th>
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</thead>
<tbody>
<tr>
<td>Agency for Healthcare Research and Quality</td>
<td>AstraZeneca HealthCare Foundation&lt;br&gt;Blue Cross/Blue Shield&lt;br&gt;Centers for Disease Control and Prevention&lt;br&gt;Centers for Medicare &amp; Medicaid Services&lt;br&gt;(Prevention Learning Network)&lt;br&gt;Community Anti-Drug Coalitions of America&lt;br&gt;Community Preventive Services Task Force&lt;br&gt;Food and Drug Administration&lt;br&gt;HealthNet&lt;br&gt;Health Resources and Services Administration&lt;br&gt;Medicaid&lt;br&gt;National Alliance of State Pharmacy Associations</td>
</tr>
<tr>
<td>Alliance for Patient Medication Safety</td>
<td>National Association of Chronic Disease Directors&lt;br&gt;National Association of County and City Health Officials&lt;br&gt;National Community Pharmacists Association&lt;br&gt;National Consumers League&lt;br&gt;National Forum for Heart Disease and Stroke Prevention&lt;br&gt;National Heart, Lung, and Blood Institute&lt;br&gt;National Institutes of Health&lt;br&gt;Pfizer Pharmaceuticals&lt;br&gt;Preventive Cardiovascular Nurses Association&lt;br&gt;RxAlly&lt;br&gt;Substance Abuse and Mental Health Services Administration&lt;br&gt;United States Department of Health and Human Services&lt;br&gt;WomenHeart&lt;br&gt;Young Men’s Christian Association</td>
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<tr>
<td>American Academy of Nurse Practitioners</td>
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<tr>
<td>American College of Cardiologists</td>
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<tr>
<td>American College of Cardiology</td>
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<td>American Heart Association</td>
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<td>American Lung Association</td>
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<tr>
<td>American Medical Association</td>
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<tr>
<td>American Pharmacists’ Association Foundation</td>
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<td>American Public Health Association</td>
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<td>American Stroke Association</td>
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<tr>
<td>America’s Health Insurance Plans</td>
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<tr>
<td>Association of State and Territorial Health Officials</td>
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<tr>
<td><strong>State Partners</strong></td>
<td></td>
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<tr>
<td>American College of Cardiologists—Iowa Chapter</td>
<td>Illinois Department of Public Health&lt;br&gt;Illinois Health Information Technology&lt;br&gt;Regional Extension Center&lt;br&gt;Illinois Hospital Association&lt;br&gt;Iowa Department of Public Health&lt;br&gt;Iowa Healthcare Collaborative&lt;br&gt;Iowa Medicaid Enterprise&lt;br&gt;Iowa Medical Society&lt;br&gt;Iowa Pharmacy Association&lt;br&gt;Iowa Primary Care Association&lt;br&gt;IPRO (New York’s QI organization)&lt;br&gt;Justus-Warren Heart Disease and Stroke Prevention Task Force and Stroke Advisory Council&lt;br&gt;Kaiser Permanente Colorado&lt;br&gt;Kansas Department of Health and Environment&lt;br&gt;KEPRO (Ohio’s QI organization)&lt;br&gt;Lillehei Heart Institute at the University of Minnesota Medical School&lt;br&gt;Maryland Department of Health and Mental Hygiene (Center for Chronic Disease Prevention and Control)&lt;br&gt;Maryland Learning Collaborative&lt;br&gt;Maryland’s Health Quality and Cost Council&lt;br&gt;Maryland State government&lt;br&gt;McCormick Corporation&lt;br&gt;MedChi&lt;br&gt;Mental Health of Delaware</td>
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<td>American College of Cardiology—Delaware Workgroups</td>
<td>New York State Department of Health&lt;br&gt;North Carolina Academy of Family Physicians&lt;br&gt;North Carolina Division of Public Health&lt;br&gt;North Carolina General Assembly&lt;br&gt;North Carolina Regional Extension Center&lt;br&gt;Ohio Academy of Family Physicians&lt;br&gt;Ohio Department of Health&lt;br&gt;Ohio State University (College of Medicine, College of Nursing, College of Pharmacy)&lt;br&gt;Oklahoma Health Care Authority&lt;br&gt;Oklahoma State Department of Health&lt;br&gt;Primaris (Missouri’s QI organization)&lt;br&gt;Progressive Community Health Centers&lt;br&gt;Quality Insights of Delaware&lt;br&gt;Quality Insights of Delaware—Regional Extension Center&lt;br&gt;State of Delaware, Division of Public Health&lt;br&gt;Stratis Health Cardiac Health Network&lt;br&gt;Telligen&lt;br&gt;Texas Department of State Health Services, CVD and Stroke Program&lt;br&gt;University of Colorado Skaggs School of Pharmacy&lt;br&gt;University of Iowa (College of Pharmacy)&lt;br&gt;University of Maryland (School of Medicine, School of Pharmacy)&lt;br&gt;University of Minnesota (Department of Family Medicine and Community Health, School of Public Health)</td>
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<td>Arkansas Cancer Coalition (Lung Cancer Workgroups)</td>
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<td>Arkansas Tobacco Prevention and Cessation Program</td>
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<td>Chesapeake Regional Information System for Our Patients (Maryland’s state health information exchange)</td>
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<td>Christiana Care Health System</td>
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<td><strong>State Partners</strong></td>
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<td>New York State Department of Health&lt;br&gt;North Carolina Academy of Family Physicians&lt;br&gt;North Carolina Division of Public Health&lt;br&gt;North Carolina General Assembly&lt;br&gt;North Carolina Regional Extension Center&lt;br&gt;Ohio Academy of Family Physicians&lt;br&gt;Ohio Department of Health&lt;br&gt;Ohio State University (College of Medicine, College of Nursing, College of Pharmacy)&lt;br&gt;Oklahoma Health Care Authority&lt;br&gt;Oklahoma State Department of Health&lt;br&gt;Primaris (Missouri’s QI organization)&lt;br&gt;Progressive Community Health Centers&lt;br&gt;Quality Insights of Delaware&lt;br&gt;Quality Insights of Delaware—Regional Extension Center&lt;br&gt;State of Delaware, Division of Public Health&lt;br&gt;Stratis Health Cardiac Health Network&lt;br&gt;Telligen&lt;br&gt;Texas Department of State Health Services, CVD and Stroke Program&lt;br&gt;University of Colorado Skaggs School of Pharmacy&lt;br&gt;University of Iowa (College of Pharmacy)&lt;br&gt;University of Maryland (School of Medicine, School of Pharmacy)&lt;br&gt;University of Minnesota (Department of Family Medicine and Community Health, School of Public Health)</td>
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<td>Young Men’s Christian Association</td>
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<td>Arkansas Department of Health Local Units Prescott and Marked Tree</td>
<td>Johns Hopkins Center to Eliminate Cardiovascular Health Disparities</td>
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<td>Health Care Access</td>
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<td>Heartland Community Clinic</td>
<td>OSF (Order of Saint Francis) Saint Francis Medical Center</td>
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<td>Ozark Technical Community</td>
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<td>College/Wellness Clinic</td>
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<td>Peoria, Illinois, City-County Health Department</td>
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<td>Vibrant Health Family Clinics</td>
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<td>Virginia Department of Health’s Heart Disease and Stroke Prevention Program</td>
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<td>Virginia Health Commissioner</td>
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<td>Virginia Health Quality Center</td>
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<td>Wisconsin Department of Health Services</td>
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<td>Wisconsin Heart Disease and Stroke Alliance</td>
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<tr>
<td>Wisconsin Nurses Association</td>
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## Appendix 2: Million Hearts Partnerships and Activities

<table>
<thead>
<tr>
<th>Resource Title</th>
<th>Key Participants</th>
<th>Goals</th>
<th>Partner Level and Audience for the Activities</th>
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| 1  “The Million Hearts™ Initiative: Progress in Preventing Heart Attacks and Strokes”  
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3461843/ | • Virginia Pharmacists Association  
• Virginia Commonwealth University School of Pharmacy  
• WomenHeart  
• Preventive Cardiovascular Nurses Association  
• Virginia Health Quality Center  
• Virginia Department of Health’s Heart Disease and Stroke Prevention Program | • The Virginia Pharmacists Association and Virginia Commonwealth University School of Pharmacy worked with employers to help screen 1 million Virginia residents for high blood pressure.  
• The WomenHeart network used materials developed by the Preventive Cardiovascular Nurses Association to educate women and families about hypertension through a network of peer mentors.  
• The Virginia Health Quality Center and Virginia Department of Health’s Heart Disease and Stroke Prevention Program led a session on how QI organizations, heart disease and stroke prevention programs, and MH partners can work together to improve Virginia’s capacity to plan, implement, track, and maintain interventions to address heart disease, stroke, etc. | Level: National and state  
Audience: Patients, pharmacists, citizens of Virginia, and medical providers |
| 2  “The Million Hearts Initiative: Applying the ABCS of Healthy Hearts in North Carolina”  
http://classic.ncmedicaljournal.com/wp-content/uploads/2012/11/NCMJ_73612_FINAL.pdf | • Carolinas Center for Medical Excellence  
• 67 practices and health centers across the state whose goal is to promote population health | • The Carolinas Center for Medical Excellence partnered with the CMS to implement meaningful use of EHRs, including reporting of the ABCS to the Physician Quality Reporting System.  
• The Carolinas Center for Medical Excellence brought together health centers across the state, gaining buy-in. | Level: National and state  
Audience: Patient population and medical providers |
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• Wisconsin Heart Disease and Stroke Alliance  
• Wisconsin Nurses Association | • The Wisconsin Collaborative for Healthcare Quality brings together 32 organizations (representing 65 percent of physicians licensed in the state), including those of employers, payers or health plans, and consumers or patients, to share ideas and evidence-based practices.  
• The Wisconsin Heart Disease and Stroke Alliance members collaborate on projects to advance prevention, screening, and treatment of heart disease and stroke. Meetings provide a forum to share clinical best and promising practices, learn from a diverse group of stakeholders, and access tools and resources beneficial to disease prevention and management. | Level: National and state  
Audience: Medical providers and patients |
| 4 “Million Hearts Initiative” http://www.stratishealth.org/providers/million-hearts.html | • Stratis Health  
• Various physician offices  
• Other community stakeholders | • The goal of the network is to bring Minnesota physician offices and local and national stakeholders together as a network aimed at improving health in populations at risk for CVD.  
• Connects providers to evidence-based interventions for heart disease and stroke.  
• Supports physician offices in implementing and measuring these evidence-based interventions.  
• Uses population health data to coordinate care more effectively for cardiac patients, reporting performance in cardiac clinical measures. | Level: State  
Audience: Medical providers and citizens |
| 5 “Million Hearts” http://www.mceita.org/?page=MillionHearts | • Michigan Center for Effective IT Adoption  
• Altarum Institute  
• Blue Cross Blue Shield of Michigan  
• CMS  
• Kresge Foundation  
• Michigan Public Health Institute  
• Medicare Quality Improvement for Michigan  
• Office of the National Coordinator of Health Information Technology  
• United Physicians  
• Upper Peninsula Health Care Network | • The partnership aims to share best practices on collecting and reporting blood pressure; reporting on the ABCS; promoting use of clinical decision support tools, patient registries, and patient reminders for high-risk patients; and providing educational tools on hypertension, heart attack, and stroke.  
• The Michigan Center for Effective IT Adoption staff work with medical providers to help meet reporting and meaningful use measures related to hypertension.  
• Encourage medical providers to take blood pressure and report in EHRs.  
• Hold webinars supporting MH. | Level: State  
Audience: Medical providers |
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| 6 “Million Hearts, Three Levers” | • ASTHO  
• CDC  
• CMS  
• Department of Health and Human Services  
• National Forum for Heart Disease and Stroke Prevention  
• AHA  
• National Association of County and City Health Officials | • Bring national partners together with state health leadership to identify key recommendations for the role of state health agencies in supporting MH.  
• ASTHO and the CDC held a ten-state, multisector learning collaborative to exchange proven strategies to improve hypertension diagnosis and control, integrate public health and clinical care, and innovatively apply QI techniques. | Level: National  
Audience: Medical providers, public health workers, insurance companies, and health departments |
| 7 “The Million Hearts™ Initiative: How Nurse Practitioners Can Help Lead” | • Nurse practitioners  
• American Academy of Nurse Practitioners | • Improve patients’ systolic blood pressure to reduce mortality rates.  
• Detect blood pressure problems in people who were previously undiagnosed.  
• Encourage nurse practitioners to join task forces to expand the use of health information technology to prevention-oriented records and design assessment tools that include the ABCS. | Level: National  
Audience: Nurse practitioners |
| 8 “The Evaluation of a Regional Faith Community Network’s Million Hearts Program” | • Washington County Health Department  
• Meritus Health System  
• ASTHO  
• Maryland Department of Health and Mental Hygiene | • The Meritus Health Parish Nurse Network project goal was to improve blood pressure control and healthy lifestyle choices among participants within the regional network.  
• The project utilizes faith community nurses and their relationships with people to improve the ABCS. | Level: Local  
Audience: Faith community nurses |
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| 9 “The Million Hearts Initiative—Targeting Key Drivers of Cardiovascular Mortality from a Medical Specialty Society Perspective” | • American College of Cardiology  
  • Cardiologists, cardiac care associates | • Use American College of Cardiology media channels to support MH—publications, the CardioSource website, email newsletters, announcements, toolkits, educational materials, etc.  
  • Increase awareness of MH among the American College of Cardiology’s 39,000 members through the college’s communication channels; drive clinical QI through clinical registries such as PINNACLE; and engage with patients through the college’s CardioSmart program. | Level: National  
  Audience: Cardiologists and cardiac care associates (nurse practitioners, physician assistants, and pharmacists) |
| 10 “Randolph-Elkins County West Virginia Blood Pressure Screening Project”     | • Randolph-Elkins County Health Department  
  • Local (West Virginia) FQHC  
  • West Virginia Chronic Disease Program | • Increase awareness of prehypertension and risk factors.                                                                                                                                                   | Level: State  
  Audience: Public health nurses |
| 11 “Disease Management to Promote Blood Pressure Control Among African Americans Fishbowl” | • CDC  
  • Agency for Healthcare Research and Quality  
  • CMS Innovation  
  • Agency for Healthcare Research and Quality Healthcare Innovation  
  • Department of Health and Human Services  
  • AHA  
  • Aetna | • Increase the rate of clinically acceptable blood pressure measurements among African American members.  
  • Measure the impact of initiatives on blood pressure and self-care knowledge and behaviors of a culturally competent disease management program relative to a light support program. | Level: National  
  Audience: Physicians, patient population (Medicare population and commercial African American population) |
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<tr>
<td>&quot;New CVD Risk-Reduction Model Promises to Pay for Results&quot;</td>
<td>• CMS • 720 practices to test the model • American College of Cardiology/AHA (who created the Million Hearts model and risk calculator)</td>
<td>• Reduce the absolute risk for heart disease or stroke among their high-risk patients using a personalized risk-modification plan that targets their specific risk factors (e.g., smoking, high blood pressure, or high cholesterol).</td>
<td>Level: National and local Audience: Participating physicians and practices</td>
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<tr>
<td>&quot;DPH Expands Access to the Georgia Tobacco Quit Line Through the Million Hearts Initiative&quot;</td>
<td>• Georgia Department of Public Health • CDC • CMS</td>
<td>• Curb the tobacco use of Medicaid enrollees in Georgia (and thus reduce prevalence of CVD).</td>
<td>Level: National and state Audience: Department of Public Health chronic disease prevention team and public health professionals</td>
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<td>&quot;Missouri Million Hearts&quot;</td>
<td>• Saint Luke’s Million Hearts • Missouri Million Hearts</td>
<td>• Transition ownership of blood pressure control to the consumer (i.e., the employees). The aim of this project (within that larger goal) was to engage several employees in activities to start this transition during Heart Health Month (February).</td>
<td>Level: State and local Audience: Hospital employees</td>
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<td>&quot;AHA, AMA Launch High Blood Pressure Initiative&quot;</td>
<td>• AHA • American Medical Association • Already partnered with 50 health care systems that serve 18 million people (e.g., University Hospitals Harrington Heart and Vascular Institute in northeast Ohio) • Hospitals, medical practices, and practitioners</td>
<td>• Equip health care providers and their patients with information and tools to keep blood pressure under control, thus potentially preventing progression to other serious threats to heart and brain health.</td>
<td>Level: National and local Audience: Employees and visitors of Saint Luke’s Hospital</td>
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<td>&quot;Heart on the Hill—May 2013&quot;</td>
<td>• AHA</td>
<td>• Campaign to galvanize advocates to urge Congress to restore and protect funding for the National Institutes of Health and Million Hearts.</td>
<td>Level: National and state Audience: Advocates consisting of researchers, patients, and medical professionals</td>
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<td>&quot;2013 Hypertension Control Champions: Cheshire Medical Center/Dartmouth-Hitchcock Keene&quot;</td>
<td>• Prevention Research Center at Dartmouth • Cheshire Medical Center/Dartmouth-Hitchcock Keene (hospital; created Hypertension Quality Improvement Team)</td>
<td>• Control the high blood pressure of residents of Cheshire County, New Hampshire.</td>
<td>Level: Local Audience: Various staff at Cheshire Medical Center/Dartmouth-Hitchcock Keene</td>
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<tr>
<td>&quot;APhA Foundation Launches Pharmacy Blood Pressure Challenge to Support the Million Hearts Initiative&quot;</td>
<td>• American Pharmacists Association • RxAlly</td>
<td>• Motivate pharmacists to talk with one patient per day about blood pressure control.</td>
<td>Level: National Audience: Pharmacists</td>
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<td>&quot;Addressing an Unmet Community Health Need&quot;</td>
<td>• Ohio State University College of Pharmacy&lt;br&gt;• Helping Hands Health and Wellness Center (free clinic in Columbus, Ohio)</td>
<td>• Empower patients with the knowledge and skills to improve cardiovascular health.&lt;br&gt;• Create a sustainability plan for the project.</td>
<td>Level: State and local Audience: Pharmacists and patients</td>
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<td>&quot;Self-Measured Blood Pressure Monitoring&quot;</td>
<td>• Agency for Healthcare Research and Quality&lt;br&gt;• America's Health Insurance Plans&lt;br&gt;• CDC&lt;br&gt;• CMS&lt;br&gt;• Health Resources and Services Administration&lt;br&gt;• National Association of Chronic Disease Directors&lt;br&gt;• National Institutes for Heart, Lung and Blood</td>
<td>• Provide action steps for public health practitioners to facilitate the implementation of self-monitoring blood pressure, plus additional support in five key areas: understanding the environment, working with payers and purchasers, working with health care providers, spreading the word to the public, and monitoring and assessing the self-monitoring of blood pressure, as well as additional support implementation.</td>
<td>Level: National Audience: Public health practitioners</td>
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<tr>
<td>&quot;Health Insurance Plans’ Innovative Initiatives to Combat Cardiovascular Disease: HealthNet&quot;</td>
<td>• HealthNet&lt;br&gt;• Providers</td>
<td>• Work with providers to educate and connect insurance plan members to programs and services that help them make healthier food choices and increase physical activity.</td>
<td>Level: National Audience: Providers and their patients who smoke or are overweight</td>
</tr>
<tr>
<td>&quot;Health Insurance Plans’ Innovative Initiatives to Combat Cardiovascular Disease: Health Plus of Michigan&quot;</td>
<td>• Health Plus of Michigan disease management nurses, pharmacists, and informatics analysts</td>
<td>• Provide physicians a list of their hypertensive patients and ask them to assess the efficacy of current medication regimens, patient lifestyle changes, diet, and medication compliance.</td>
<td>Level: State and local Audience: Providers</td>
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| “Offering a Trim, a Shave, and a Blood Pressure Check” http://stakeholderhealth.org/barber-health/ | • MedStar Health (a ten-hospital nonprofit system)  
• Barbershops in the Washington, D.C./Maryland area  
• AstraZeneca HealthCare Foundation (provided the funds) | • Identify individuals at risk for heart disease, stroke, and end-stage kidney disease in barbershops and hair salons. | Level: State and local  
Audience: Barbers |
| “2014 State/Local Million Hearts Projects: District of Columbia Department of Health” | • District of Columbia Primary Care Association and Unity Healthcare  
• District of Columbia Department of Health | • Public health nurses trained primary care nurses on how to administer appropriate follow-up for patients with undiagnosed and uncontrolled high blood pressure. | Level: Local  
Audience: Primary care nurses |
| “2014 State/Local Million Hearts Projects: Duchess County New York”           | • Public health nurses in Poughkeepsie, New York (at the Duchess County Department of Health)  
• Hudson Health Center (FQHC) | • Improve hypertension control rates among patients who visit this FQHC. | Level: Local  
Audience: Public health nurses |
| “2014 State/Local Million Hearts Projects: Illinois Local Health Department Well Woman Project” | • Stephenson County Health Department nurses and 250 providers (doctors, nurse practitioners, and hospitals) contracted to refer people to the program  
• Well Woman Project | • Educate patients on their lab values, healthy eating, and physical activity. | Level: Local  
Audience: Nurses and other health care providers, as well as women aged 35–64 who are 250 percent below the poverty level |
| “2014 State/Local Million Hearts Projects: Minnesota Regional Community Health Board” | • Minnesota Department of Health  
• Minnesota Regional Community Health Board  
• Eight primary care clinics | • The goal is to reduce patients’ risk for developing heart disease and diabetes. Four of the clinics are also implementing evidence-based strategies to address identification and control of hypertension through the Million Hearts Initiative. | Level: Local  
Audience: Practitioners |
| “2014 State/Local Million Hearts Projects: New Hampshire Local Health Department” | • Lamprey Health Care  
• New Hampshire Department of Health and Human Services  
• Cheshire Medical Center (Keene, New Hampshire) | • Identify individuals with high blood pressure and refer them to Lamprey Health Center (the local FQHC). | Level: State and local  
Audience: Clients assessing immunization services and STD clinics |
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| “2014 State/Local Million Hearts Projects: Oklahoma’s Heartland Project”     | • McAlester Regional Health Center  
• Warren Clinic  
• Choctaw Nation Health Services (Indian Health Services)  
• Caring Hands FQHC  
• Local pharmacists | • Implement a team-based model of care that includes a clinician, public health nurse care coordinator, pharmacist, and patient to respond to higher-than-average hypertension diagnoses in four counties in southeastern Oklahoma. | Level: Local Audience: Clinicians, public health nurses, pharmacists, and patients |
| “2014 State/Local Million Hearts Projects: Peoria, Illinois Partnership with Faith Communities” | • Peoria, Illinois, City-County Health Department  
• Faith community nurses from five local churches  
• Heartland Community Clinic  
• Unity Point Methodist Medical Center and OSF (Order of Saint Francis) Saint Francis Medical Center  
• Local nephrologists | • Lead church members toward a heart-healthy lifestyle. The faith community nurses do this by working with community members to conduct blood pressure screenings and provide education and support to community members. | Level: Local Audience: Faith community nurses |
| “Million Hearts – Exploring the Role of RECs: NC REC’s ‘Change Package’ Model Supports Million Hearts Efforts” | • North Carolina Regional Extension Center  
• Providers in North Carolina | • Implement strategies that help practices identify, monitor, and treat patients who have CVD or are at risk for CVD. | Level: State and local Audience: Providers |
| “Million Hearts—Exploring the Role of RECs: QIDE REC Evaluates Provider Performance on Million Hearts and Redesigns Workflows” | • QIDE Regional Extension Center  
• 155 providers | • Help providers evaluate their performance on the Million Hearts clinical quality measures and redesign workflows accordingly when improvement is needed. | Level: State and local Audience: Providers looking to meet requirements for meaningful use and medical homes |
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| “Million Hearts—Exploring the Role of RECs: NYC REACH Helps New York Providers Engage Patients in Million Hearts” | • New York City Regional Electronic Adoption Center for Health  
• Providers in New York City | • Help New York City providers optimize their EHR systems and encourage patients to become more engaged in their health and health care. | Level: Local  
Audience: Providers |
| “Million Hearts—Exploring the Role of RECs: HITArkansas Engages Community Partners to Promote Million Hearts” | • Health Information Technology Center for Arkansas  
• Providers  
• Community stakeholders  
• Patients | • Help providers leverage health IT for Million Hearts, educate patients about the ABCS, and build support for MH among key community stakeholders. | Level: State and local  
Audience: Providers |
| “Million Hearts® Delaware: Collaborating to Save a Million Hearts by 2017”   | • Christiana Care Health System  
• Delaware Center for Health Promotion at Delaware State University  
• Delaware Academy of Family Physicians  
• Delaware Academy of Medicine  
• Delaware Chapter of the American Heart Association  
• Delaware Greenways  
• Delaware Healthcare Association  
• Medical Society of Delaware  
• Nemours Alfred I. duPont Hospital for Children  
• Quality Insights of Delaware  
• American College of Cardiology—Delaware  
• State of Delaware, Division of Public Health | • Improve care for people who need treatment by encouraging health care professionals to target their focus on the ABCS, which address the major risk factors for CVD and can help prevent heart attacks and strokes. | Level: State  
Audience: Health care professionals, hospitals, government, employers, and residents |
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<td>“Million Hearts’ Targets Cardiovascular Disease, Stroke”</td>
<td>• Arkansas Foundation for Medical Care Organization for Arkansas • CMS</td>
<td>• Engage in clinical and community prevention efforts to work toward the MH campaign goals.</td>
<td>Level: National and state Audience: Providers</td>
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<tr>
<td>“Meeting the Million Hearts Goal”</td>
<td>• HealthPartners (integrated health care system based in Bloomington, Minnesota) • MH organizers</td>
<td>• Prevent or postpone 132 events per 100,000 persons ages 40 to 74.</td>
<td>Level: State Audience: Health plan members, patients, employees, students, teachers, community members, and the general public</td>
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<td><a href="http://pubs.royle.com/article/Meeting_The_Million_Hearts_Goal/1388821/157096/article.html">http://pubs.royle.com/article/Meeting_The_Million_Hearts_Goal/1388821/157096/article.html</a></td>
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<td>“Million Hearts Case Study: Ohio’s ‘Check It, Change It, Control It’ Toolkit”</td>
<td>• Ohio Department of Health • Ohio Academy of Family Physicians</td>
<td>• Improve blood pressure among African American males across Ohio. “[The toolkit] was designed to increase screening among African-American males for hypertension and high cholesterol and improve their preventive behaviors and treatment by focusing on both patient education and physician training in care management and cultural sensitivity.”</td>
<td>Level: State Audience: Primary care physicians</td>
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<td><a href="http://www.astho.org/Programs/Prevention/Chronic-Disease/Million-Hearts/Case-Study-OH/">http://www.astho.org/Programs/Prevention/Chronic-Disease/Million-Hearts/Case-Study-OH/</a></td>
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<td>“Million Hearts Case Study: Iowa’s Million Hearts Initiative”</td>
<td>• Iowa Department of Public Health • Iowa Healthcare Collaborative • Telligen • University of Iowa College of Pharmacy</td>
<td>• Leverage partnerships across sectors to support components of MH, particularly improving quality of care around the ABCS of heart health. Key components of this work include supporting team-based care models for blood pressure management, incorporating MH goals into state-level strategic planning efforts, and educating health care professionals and the public about MH and how to get involved.</td>
<td>Level: State Audience: Health care professionals, oral care professionals, patients, and community</td>
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<td><a href="http://www.astho.org/Programs/Prevention/Chronic-Disease/Million-Hearts/Case-Study-IA/">http://www.astho.org/Programs/Prevention/Chronic-Disease/Million-Hearts/Case-Study-IA/</a></td>
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| 40| “Community-Clinical Linkages to Improve Hypertension Identification, Management, and Control” | - Ohio Department of Health  
- Ohio Academy of Family Physicians  
- Summit County Public Health  
- KEPRO (the state QI organization)  
- 11 family practices in Summit County  
- Fire/emergency medical services stations | - Develop an integrated community-clinical system to screen, identify, manage, and refer individuals with hypertension to clinical and community resources to support better self-management of blood pressure. | Level: State and local  
Audience: Community members and patients in Summit County, Ohio |
| 41| “Community-Clinical Linkages to Improve Hypertension Identification, Management, and Control [New Hampshire]” | - Manchester Health Department  
- YMCA  
- Community health centers | - Reduce risk of hypertension by referring at-risk patients to a YMCA program to engage in physical activity. | Level: Local  
Audience: Community health centers |
| 42| “Community-Clinical Linkages to Improve Hypertension Identification, Management, and Control [Maryland]” | - Maryland Department of Health and Mental Hygiene  
- State health information exchange  
- Local health care providers  
- Local health departments  
- Community-based chronic disease prevention and control resources | - Reduce readmissions and facilitate the utilization of lower-cost outpatient health care services.  
- Increase the ability of community organizations to document when they provide services and link that information back to providers when they are seeing patients. | Level: State and local  
Audience: Community organizations, providers, and health department workers |
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<tr>
<td>&quot;Community Clinical Linkages to Improve Hypertension Identification, Management, and Control [Arkansas]&quot;</td>
<td>• Arkansas Department of Health Local Units Prescott and Marked Tree • Clinicians</td>
<td>• Address hypertension in Nevada and Poinsett Counties by providing community team-based care for patients with uncontrolled hypertension.</td>
<td>Level: State and local Audience: Clinicians</td>
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<tr>
<td>&quot;Community Clinical Linkages to Improve Hypertension Identification, Management, and Control [Kansas]&quot;</td>
<td>• Kansas Department of Health and Environment • Health Care Access • Health care providers</td>
<td>• Standardize blood pressure measurement training for health care providers.</td>
<td>Level: State and local Audience: Providers</td>
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<td>&quot;Million Hearts In-Depth Case Study: New York Cardiac Population Health Initiative&quot;</td>
<td>• New York State Department of Health • IPRO (New York’s designated QI organization) • Catholic Medical Partners • Southgate Medical Group • Northtowns Cardiology • MEDENT</td>
<td>• By July 2014, reduce risk factors and improve health outcomes for patients with CVD or at high risk of developing CVD in approximately 150 primary care practices across New York State through improvements in the ABCS. The initiative is part of the national cardiac population health initiative, which aims to reduce major risk factors for heart disease and stroke (high blood pressure, high cholesterol, and smoking) by contracting with QI organizations in each state to improve cardiac care management at the health care practice level.</td>
<td>Level: State and local Audience: Primary care practices with an EHR system in New York State</td>
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| 46 | “Million Hearts Case Study: Maryland’s Million Hearts Initiative” | • Maryland Department of Health and Mental Hygiene  
• “Grasstope” partners (e.g., “key leaders in state government, healthcare systems, universities, insurance providers, and others through Maryland’s Health Quality & Cost Council”)  
• “In the grass” partners (e.g., “mid-level management and professionals such as healthcare providers, insurance professionals, academics, and others”)  
• “On the ground” partners (e.g., “community- and faith-based organizations, local health improvement coalitions, federally qualified health centers, community health centers, local health departments, and others that work directly with target populations”) | • Support the national MH Initiative through broad state-level efforts that leverage existing activities and engage key state and local partners in many sectors to improve cardiovascular health for all Marylanders. | Level: State and local  
Audience: Patients and providers in coordinated care models for chronic disease prevention and management |
| 47 | “Healthy Hearts for Marylanders” | • Maryland Department of Health and Mental Hygiene’s Center for Chronic Disease Prevention and Control  
• Mid-Atlantic Association of Community Health Centers  
• Two FQHCs in Baltimore | • Improve quality of care and health outcomes related to HbA1c (hemoglobin A1c), blood pressure, cholesterol, and smoking cessation among patients with diabetes at FQHCs across Maryland. | Level: State and local  
Audience: Maryland residents from 18 to 75 years of age with a type 2 diabetes diagnosis and at least one documented blood pressure reading, HbA1c measurement, and low-density lipoprotein cholesterol measurement at a participating FQHC |
| 48 | “Maryland P3 Program” | • Maryland Department of Health and Mental Hygiene  
• University of Maryland School of Pharmacy  
• Local pharmacists  
• Employers (Maryland State government and McCormick Corporation) | • Improve hypertension and diabetes prevention and control by partnering with community pharmacists to provide medication therapy management services to employees of self-insured employers across the mid-Atlantic region, including Maryland; in Maryland, the program has focused on diabetes management. | Level: State and local  
Audience: Employees of Maryland State government and McCormick Corporation and their family members who have been diagnosed with diabetes |
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<td>“DC Identifies Patients with Uncontrolled and Undiagnosed Hypertension”</td>
<td>• District of Columbia Department of Health&lt;br&gt;• Health care partner sites across the District of Columbia, including community health centers and hospital systems, in Wards 5 and 7</td>
<td>• Work to identify patients with uncontrolled and undiagnosed hypertension to provide targeted interventions and referrals to community resources.</td>
<td>Level; Local Audience: Various community health centers and hospital systems, as well as African American residents ages 18 and older living in Wards 5 and 7 in the District of Columbia</td>
</tr>
<tr>
<td>“Illinois Uses Hospital Discharge Data to Support Local Hypertension Control Efforts”</td>
<td>• Illinois Department of Public Health&lt;br&gt;• Partners in Macon and Peoria Counties, including local public health agency staff, federally qualified health centers, and public health nurses</td>
<td>• Work to analyze and share data on hypertension-related hospital discharges to inform local activities addressing hypertension.</td>
<td>Level: State and local Audience: County-level health partners and populations in Macon and Peoria Counties with hypertension</td>
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<td>“New York Develops Clinical Pathway to Identify and Manage Adult Hypertension”</td>
<td>• Whitney M. Young, Jr., Health Center (a FQHC and patient-centered medical home in Albany, New York)&lt;br&gt;• New York State Department of Health&lt;br&gt;• Other state and local partners</td>
<td>• Develop and implement a set of clinical practice guidelines to create a “clinical pathway” that leverages team-based care and patient self-management to improve identification and clinical management of hypertension.</td>
<td>Level: State and local Audience: Patients aged 18–85 with undiagnosed hypertension and patients with a diagnosis of hypertension in their medical record but whose hypertension is uncontrolled at the Whitney M. Young, Jr., Health Center</td>
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| 52 “Medicaid and Million Hearts: Leveraging Interagency Partnership [Vermont]” | • Vermont Department of Health  
• Department of Vermont Health Access (Medicaid) | • Use Medicaid claims data to address clinical practice around hypertension. Medicaid data was analyzed to calculate medication possession ratios, which were sent to providers to inform their clinical practice. | Level: State  
Audience: Providers |
| 53 “Medicaid and Million Hearts: Leveraging Interagency Partnership [Oklahoma]” | • Oklahoma State Department of Health  
• Oklahoma Health Care Authority (Medicaid) | • Address CVD by improving care coordination and promoting appropriate clinical practice for those with hypertension. | Level: State  
Audience: Nurse care coordinators |
| 54 “Engaging Partners for Million Hearts Success [Colorado]”                  | • Colorado Department of Public Health and Environment  
• AHA  
• Kaiser Permanente Colorado  
• Colorado Prevention Center  
• Walgreens  
• Local public health agencies  
• Colorado Regional Health Information Organization  
• Telligen  
• University of Colorado Skaggs School of Pharmacy  
• Regis University School of Pharmacy  
• American College of Cardiologists  
• Others | • Reduce heart attacks and strokes in Colorado with six strategies focused on the goals of increasing awareness of hypertension and improving care and management of CVD. | Level: National, state, and local  
Audience: Providers |
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| **55** “Engaging Partners for Million Hearts Success [Wisconsin]”  [Link](https://c.ymcdn.com/sites/chronicdisease.site-ym.com/resource/resmgr/CVH/Million_Hearts_Stakeholders__pdf) | • Wisconsin Division of Public Health  
• Wisconsin Heart Disease and Stroke Alliance  
• Wisconsin Department of Health Services | • Capture successful efforts that have led to improved blood pressure control and management outcomes.  
• Engage in strategies to address hypertension and improve patient care. | Level: State and local  
Audience: Individual and team participants from health systems, clinics, programs, or community agencies |
| **56** “Engaging Partners for Million Hearts Success [Illinois]”  [Link](https://c.ymcdn.com/sites/chronicdisease.site-ym.com/resource/resmgr/CVH/Million_Hearts_Stakeholders__pdf) | • Illinois Department of Public Health  
• Illinois Primary Health Care Association  
• Illinois Academy of Family Practice  
• Midwest Group on Business  
• AHA  
• Illinois Hospital Association  
• Illinois Health Information Technology Regional Extension Center  
• Blue Cross/Blue Shield  
• Telligen (the state QI organization)  
• Several large health care systems | • Develop activities to address hypertension in the community. | Level: National and state  
Audience: Community members in counties in Illinois |
| **57** “Engaging Partners for Million Hearts Success [Iowa]”  [Link](https://c.ymcdn.com/sites/chronicdisease.site-ym.com/resource/resmgr/CVH/Million_Hearts_Stakeholders__pdf) | • Iowa Department of Public Health  
• American College of Cardiologists—Iowa Chapter  
• AHA  
• Midwest Affiliate  
• Iowa Healthcare Collaborative  
• Telligen  
• YMCA  
• Iowa Pharmacy Association  
• Iowa Medical Society  
• Iowa Medicaid Enterprise  
• University of Iowa  
• Veterans Affairs Central Iowa Health System  
• Iowa Pharmacy Association  
• Iowa Primary Care Association  
• YMCA in Greater Des Moines Association | • Engage in activities to address hypertension and disparities.  
• Focus specifically on team care and coordination, provider-pharmacist teams, hypertension protocols, patient self-measured blood pressure with clinical monitoring, referral to community resources, use of EHRs and registries, and addressing disparities. | Level: National, state, and local  
Audience: Health care practices |
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| 58 "Engaging Partners for Million Hearts Success [Texas]"  
https://c.ymcdn.com/sites/chronicdisease.site-ym.com/resource/resmgr/CVH/Million_Hearts_Stakeholders_.pdf | • Texas Department of State Health Services  
• CVD and Stroke Program  
• Local health departments, universities, clinics, the state QI organization, insurance, and nonprofits | • Promote the use of community health workers and QI in order to control hypertension. | Level: State and local  
Audience: Community health workers and QI workgroups |
| 59 "Engaging Partners for Million Hearts Success [Missouri]"  
https://c.ymcdn.com/sites/chronicdisease.site-ym.com/resource/resmgr/CVH/Million_Hearts_Stakeholders_.pdf | • Missouri Department of Health and Senior Services  
• Kansas City CARE Clinic  
• FQHCs  
• Saint Luke’s Hospital  
• AHA  
• University of Missouri Center for Health Policy  
• Missouri Nurses Association  
• Pfizer Pharmaceuticals, Health and Human Services, Region VII  
• Health Literacy Missouri  
• Saint Louis Heart and Vascular Cardiology  
• Local county health  
• Primaris (the state QI organization) | • Develop an understanding of team-based care and its potential for enhancing the quality of the ABCS in primary care settings.  
• Develop a deeper understanding of the positive outcomes from using the ABCS from practitioners in clinical settings.  
• Synthesize information pertaining to team-based care and the ABCS to highlight issues, barriers, and possible solutions to ascertain next steps. | Level: National, state, and local  
Audience: Stakeholders in team-based care and primary care |
| 60 “Hypertension Awareness Day at the North Carolina General Assembly”  
http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_473696.pdf | • Justus-Warren Heart Disease and Stroke Prevention Task Force  
• AHA/American Stroke Association  
• Policymakers, cardiovascular experts  
• North Carolina Academy of Family Physicians  
• Prevention Committee of the Justus-Warren Heart Disease and Stroke Prevention Task Force Stroke Advisory Council  
• Carolinas Center for Medical Excellence  
• Consortium for Southeastern Hypertension Control | • Raise awareness about the prevention, risk, prevalence, management, and costs associated with high blood pressure. | Level: National and state  
Audience: Lawmakers, their staff, and the general public (in North Carolina) |
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| 61 “Arkansas Million Hearts Initiative”                                        | • Arkansas Foundation for Medical Care  
• Arkansas Chronic Illness Collaborative Practice Teams  
• Arkansas Chronic Disease Coordinating Council  | • Decrease the number of heart attacks and strokes among Arkansans and improve the overall health outcomes of state citizens.                                                                                   | Level: State  
Audience: Medical practices and residents in Arkansas                                                                                                                                          |
| http://www.healthy.arkansas.gov/programs/chronicDisease/HeartDiseaseandStrokePrevention/Pages/MillionHearts.aspx |                                                                                                                                                               |                                                                                                                                                                                                   |                                               |
| 62 “Chronic Disease Coordinating Council Million Hearts Action Plan [Cancer]”  | • Arkansas Cancer Coalition  
• Arkansas Foundation for Medical Care  
• AHA  
• Tobacco Prevention and Cessation Program  
• Arkansas Department of Health Chronic Disease Prevention and Control Branch  
• Arkansas Chronic Disease Coordinating Council (action step 1)  
• Arkansas Cancer Coalition Lung Cancer Workgroups (action step 2)  | • Incorporate MH principles and goals into all patient and professional educational materials and activities, in both clinical and community settings.                                               | Level: National and state  
Audience: General public and health organizations in Arkansas                                                                                                                                 |
| 63 “Chronic Disease Coordinating Council Million Hearts Action Plan [Heart Disease and Stroke]” | • Arkansas coalitions (action step 1)  
• Arkansas Chronic Disease Coordinating Council; Tobacco Prevention and Cessation Program; Community Health Clinic (action step 2)  | • Promote use of MH messages, resources, and tools.                                                                                                                                                 | Level: State and local  
Audience: Health organizations and community in Arkansas                                                                                                                                         |
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| 64 "Chronic Disease Coordinating Council Million Hearts Action Plan [Oral Health]" | - Arkansas Oral Health Coalition, consisting of school health wellness clinics, public and private health care providers, and other health-related coalitions  
- Medicaid representatives  
- American Student Dental Association  
- Arkansas State Dental Hygienists Association  
- Arkansas Medicaid | - Develop and launch a dental health education program for all ages that emphasizes the importance of oral health to systemic health, incorporating MH components. | Level: State  
Audience: Dental professionals |
| 65 "Chronic Disease Coordinating Council Million Hearts Action Plan [Tobacco]" | - Public health and health care sector partners  
- Arkansas Foundation for Medical Care  
- Systems Training Outreach Program | - Integrate MH goals into tobacco-related professional and patient education. | Level: State  
Audience: Health care providers and professionals and community members in Arkansas |
| 66 "Southeast Region Hometown Health Improvement Newsletter: News You Can Use—June 2013" | - Arkansas Foundation for Medical Care  
- University of Arkansas for Medical Sciences East–Lake Village  
- New Hope Missionary Baptist Church  
- Others | - Hold Healthy Heart and Stroke Summits to educate people on heart health, conduct screenings, and ultimately improve cardiovascular health in the community. | Level: State and local  
Audience: General public |
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| “Program Focus”                                                               | • Arkansas Minority Health Commission  
  • Arkansas Medical Dental and Pharmaceutical Association  
  • Arkansas State Board of Barber Examiners  
  • Arkansas Foundation for Medical Care  
  • Baptist Health  
  • Hola! Media Group                                                            | • Increase public awareness about heart disease and stroke.  
  • Empower minorities to better understand hypertension prevention and management. | Level: State and local  
  Audience: Minority community members in locally owned barber and beauty shops, colleges, and salons |
| “Next Steps for Addressing Cardiovascular Disease in California”              | • Health Insurance Exchange  
  • Health information technology  
  • Health informatics  
  • FQHCs  
  • Community clinics  
  • Nongovernmental health organizations  
  • Health plans  
  • California Department of Health Care Services  
  • National Association of Chronic Disease Directors                         | • Leverage meaningful use and EHRs to improve electronic health information exchange to support team-based care to improve the control of high blood pressure. | Level: National, state, and local  
  Audience: Providers                                                      |
| “Health Disparities in the Medi-Cal Population”                              | • California Department of Health Care Services  
  • CMS Prevention Learning Network                                               | • Advance Million Hearts, specifically focusing on tobacco cessation and hypertension control.      | Level: National and state  
  Audience: Medi-Cal leadership                                              |
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<td>70 &quot;Wellness and Prevention Workgroup Update—March 18, 2013&quot;</td>
<td>• Maryland Health Quality and Cost Council&lt;br&gt;• Maryland Department of Health and Mental Hygiene&lt;br&gt;• Perdue Farms&lt;br&gt;• Johns Hopkins Center to Eliminate Cardiovascular Health Disparities&lt;br&gt;• MedChi&lt;br&gt;• CareFirst BlueCross BlueShield&lt;br&gt;• MedStar&lt;br&gt;• Washington Adventist Hospital&lt;br&gt;• University of Maryland School of Medicine</td>
<td>• Raise awareness, align and guide statewide efforts, engage public and private partners, and highlight best practices and resources that achieve excellence in the ABCS.</td>
<td>Level: State and local Audience: Organizations in Maryland attending symposium</td>
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<td>71 &quot;Wellness and Prevention Workgroup Update—September 19, 2014&quot;</td>
<td>• Maryland Department of Health and Mental Hygiene&lt;br&gt;• Medicaid&lt;br&gt;• Local health departments&lt;br&gt;• Chesapeake Regional Information System for Our Patients (state health information exchange)&lt;br&gt;• EHRs, local health improvement coalitions, pharmacists, faith communities, and fire stations&lt;br&gt;• Delmarva&lt;br&gt;• Mid-Atlantic Association of Community Health Centers&lt;br&gt;• Maryland Learning Collaborative&lt;br&gt;• Hospitals, primary care practices, FQHCs, specialists, etc.</td>
<td>• Promote MH resources internally and externally.&lt;br&gt;• Ensure wellness and prevention strategies are incorporated into the Evidence-Based Medicine Workgroup’s value-based insurance design efforts.</td>
<td>Level: State and local Audience: Partners and community members in Maryland</td>
</tr>
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<td>72 &quot;Medicaid Quality Strategy: HealthChoice Program: 2012–2016&quot;</td>
<td>• Maryland Department of Health and Mental Hygiene&lt;br&gt;• Center for Chronic Disease Prevention and Control</td>
<td>• MH in Maryland set out to improve clinical and community linkages through the use of community health workers and community referrals. By June 30, 2014, its goal was to decrease emergency department visits for high blood pressure by 5 percent and to improve blood pressure control by 5 percent among residents in Baltimore City, Cecil, Saint Mary’s, and Washington Counties, especially among low-income and uninsured individuals.</td>
<td>Level: State and local Audience: Community health workers</td>
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| “Million Hearts” (Ohio State University)                                      | 1. Ohio State University College of Nursing  
2. Ohio State University College of Medicine  
3. Ohio State University College of Pharmacy                                                                                                          | 1. Educate health care professional students and health care professionals on the MH initiative.  
2. Increase MH screenings and education nationwide.  
3. Improve population cardiovascular health.                                                                                                         | Level: State  
Audience: General public                                                                                                                                  |
| [https://millionhearts.osu.edu/](https://millionhearts.osu.edu/)                |                                                                                                                                                                                                                  |                                                                                                                                                                                                       |                                                                                     |
| “Ask About Aspirin” [http://askaboutaspirin.umn.edu/about-heart-health-program/](http://askaboutaspirin.umn.edu/about-heart-health-program/) | 1. Lillehei Heart Institute at the University of Minnesota Medical School  
2. School of Public Health  
3. Department of Family Medicine and Community Health  
4. CentraCare Health System  
5. Essentia Health  
6. Fairview  
7. Fairview Range Mesaba  
8. Lakewood Health System  
9. Mankato Clinic  
10. Minnesota Department of Health  
11. Saint Luke’s                                                                                                                                   | 1. Promote the appropriate use of low-dose aspirin to lower the number of first heart attacks and strokes in Minnesota.                               | Level: State and local  
Audience: Men ages 45–79 and women ages 55–79, patients, and providers in Minnesota                                                                 |
References

Association of State and Territorial Health Officials, Million Hearts Case Study: Maryland’s Million Hearts Initiative, 2013. As of August 15, 2017:
http://www.astho.org/Presidents-Challenge-2013/Maryland/


———, New York Develops Clinical Pathway to Identify and Manage Adult Hypertension, 2014b.

ASTHO—See Association of State and Territorial Health Officials.


MetaStar. “Atrium Partners.” As of January 6, 2016:

Office of Disease Prevention and Health Promotion, “Healthy People 2020.” As of August 15, 2017:

Office of the National Coordinator for Health Information Technology, Education and Outreach Case Study: Million Hearts—Exploring the Role of RECs, 2016. As of August 15, 2017:

