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Nevada Department of Health and Human Services

Division of Public and Behavioral Health

Bureau of Child, Family and Community Wellness

Chronic Disease Prevention and Health Promotion Section

Nevada Heart Disease and Stroke Prevention Strategic Plan

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# Introduction

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Heart disease is the leading cause of death nationwide and in Nevada[[1]](#footnote-1), while stroke is the fifth-leading cause nationwide and fourth in Nevada.[[2]](#footnote-2) Many factors increase the risk of heart disease and stroke: tobacco use, physical inactivity, obesity/overweight, high blood pressure, and high cholesterol. Thirty-three percent of Nevadans were diagnosed with hypertension by their primary care provider, and 33.1% of Nevadans who had their blood pressure checked were told it was high.[[3]](#footnote-3) Primary risk factors for cardiovascular disease (CVD), such as hypertension and high blood cholesterol, can be managed with lifestyle changes. Yet, many Nevadans suffering from or at-risk for developing these conditions do not receive appropriate or timely intervention and/or treatment. A close up of a person

Description generated with high confidence

# Background

Nevada’s Heart Disease and Stroke Prevention (HDSP) Program was established in 2013 within the Chronic Disease Prevention and Health Promotion Section of the Nevada Division of Public and Behavioral Health’s Bureau of Child, Family and Community Wellness. The HDSP Program’s goal is to prevent and reduce premature death and disability from heart disease and stroke among Nevadans. The HDSP Program is 100% federally-funded by the Centers for Disease Control and Prevention (CDC).

The objectives of the HDSP Program are:

* Build a strong health systems infrastructure by strengthening and promoting partnerships among state and local agencies, schools, universities, healthcare organizations, businesses, and non-profit agencies;
* Identify gaps and challenges in clinical systems to address the burden of heart disease and stroke;
* Increase quality improvement standards of cardiac and stroke care in Nevada using evidence-based guidelines; and
* Implement and promote policy and systems change interventions to address the burden of heart disease and stroke in Nevada.

A key resource for the HDSP Program is Nevada’s HDSP Task Force, which is comprised of over 60 members from organizations including the Nevada Hospital Association, the Nevada Primary Care Association, Nevada Rural Hospital Partners, the American Heart Association/American Stroke Association, HealthInsight Nevada, Southern Nevada Health District, Washoe County Health District, Carson City Health and Human Services, Renown Health, Desert Springs Hospital, University Medical Center, stroke and cardiac coordinators, physician champions, and patient representatives and advocates.

In August 2014, HDSP Task Force members convened to review data and outcomes of a situational analysis related to heart disease and stroke in Nevada. In 2015, with technical assistance from the CDC and the American Heart Association (AHA), Nevada convened multiple meetings to identify priorities and goals for a five-year Strategic Plan that would align new initiatives, such as the [Million Hearts®](https://millionhearts.hhs.gov/) Initiative, with existing efforts to address and reduce the burden of heart disease and stroke. The goal of the meetings was to leverage and coordinate efforts into a clear, cohesive Heart Disease and Stroke Prevention Strategic Plan for Nevada.

In November 2017, the state reconvened members of the HDSP Task Force to review and revise the Strategic Plan. The following update encompasses the work of Task Force members who participated in an all-day strategic planning meeting in November 2017. The updated Strategic Plan includes statewide activities specified in the recently awarded CDC “1815” Cooperative Agreement, which funds the evidence-based strategies being implemented in Nevada to prevent and manage CVD, and the activities specified in the competitive CDC “1817” Grant, which funds innovative approaches to reduce the burden of heart disease and stroke in Nevada.

# Nevada Strategic Plan Mission and Principles

**Mission**

To establish and implement a comprehensive plan for the prevention of stroke, heart disease, and other vascular diseases in Nevada.

**Principles**

* Decisions and strategies should be data driven
* Decisions and strategies should be outcome-oriented
* A person holding his hands up

  Description generated with very high confidenceStrategies and programs should be sustainable
* Interventions in the Strategic Plan should be based on evidence and practical implementation
* Efforts to address the burden of CVD should be coordinated among statewide partners
* The Strategic Plan should be focused on comprehensive, coordinated, chronic disease prevention activities

# Goals and Activities

During the 2017 Task Force Strategic Planning Meeting, participants reviewed the goals, strategies, and targets developed in 2015. Updates were made to clarify activities and identify specific targets for making improvements to Nevada’s heart disease and stroke prevention and intervention network.

#### Goal 1: Promote the adaptation of evidence-based quality measurement at the provider level.

Activity 1.1: Identify and implement key quality measures related to CVD in clinical settings for quality improvement to reduce healthcare disparities.

Activity 1.2: Promote the American Heart Association’s Get With The Guidelines-Stroke Registry Program to Nevada’s comprehensive stroke centers.

Activity 1.3: Update Nevada’s High Blood Pressure and Stroke Toolkits and disseminate to providers statewide.

Activity 1.4: Identify underserved populations with a high burden of CVD and prioritize and bridge gaps to improve prevention, management, and treatment.

#### Goal 2: Support engagement of non-physician team members in hypertension and cholesterol management in clinical settings.

Activity 2.1: Engage statewide partners and stakeholders, including non-physician members, to participate in Nevada’s HDSP Task Force meetings.

Activity 2.2: Promote self-management of CVD among high-risk populations in Nevada by engaging non-physician team members in comprehensive care management programs targeting both clinical and nonclinical aspects of hypertension and cholesterol management.

Activity 2.3: Explore and test innovative ways to engage non-physician team members (e.g., nurses, nurse practitioners, pharmacists, nutritionists, physical therapists, social workers, etc.) in hypertension and cholesterol management in clinical settings.

Activity 2.4: Engage non-physician team members, such as Registered Dietitians, Dietetic Interns, Registered Nurses, and/or Medical Assistants, to provide dietary education for managing hypertension and high cholesterol levels to patients in underserved areas.

**Goal 3: Promote the adaptation of Medication Therapy Management (MTM) between pharmacists and physicians to improve management of hypertension, high cholesterol, and lifestyle modification.**

Activity 3.1: Engage health systems in adaptation of MTM for patients with hypertension, and/or high cholesterol.

Activity 3.2: Develop a clinical protocol for provision of MTM in clinical settings for improved communication flow among pharmacists, physicians, and other care team members.

Activity 3.3: Increase statewide infrastructure and sustainable systems in provision of MTM through innovative approaches.

Activity 3.4: Explore and test innovative ways to provide MTM services to adults with hypertension and high blood cholesterol living in underserved areas by working with community pharmacists and physicians.

#### Goal 4: Facilitate use of the Self-Monitoring Blood Pressure (SMBP) Program with clinical support among adults with hypertension.

#### Activity 4.1: Disseminate to healthcare providers statewide the step-by-step guidelines for implementing the SMBP Program.

Activity 4.2: Promote implementation and evaluation of the program in clinical settings.

Activity 4.3: Engage appropriate care-team members to enroll eligible patients into SMBP Programs in clinical settings.

**Goal 5: Implement systems to facilitate systematic referral of adults with hypertension and/or high blood cholesterol to community programs and resources.**

#### Activity 5.1: Identify, implement, and evaluate community-based interventions targeting adults at-risk for or with hypertension and/or high cholesterol.

#### Activity 5.2: Implement, monitor, and evaluate the Barber Shop Hypertension Outreach Program (BSHOP), which provides blood pressure screenings, education, and referrals to community and medical services at barbershops in the African American community in Clark County, NV.

#### Activity 5.3: Develop, implement, and evaluate the Beauty Salon Hypertension Outreach Program (BESHOP), which provides blood pressure screenings, education, and referrals to community and medical services at beauty salons serving predominantly African American females in Clark County, NV.

#### Activity 5.4: Integrate Community Health Workers (CHWs) into community-based interventions to enhance engagement of adults at-risk for or with hypertension and/or high blood cholesterol to improve self-management.

#### Activity 5.5: Conduct asset mapping in three (3) counties (Carson City, Douglas, and Lyon) to create and disseminate a referral resource guide, including a list of community programs.

#### Activity 5.6: Expand referral systems in Electronic Health Records (EHRs) to systematically refer patients to education and social resources in the community.

Activity 5.7:Partner with Project ECHO at the University of Nevada, Reno to enhance training resources available statewide.[[4]](#footnote-4)

#### Goal 6: Test, develop, and evaluate innovative strategies to prevent and manage CVD.

#### Activity 6.1: Develop and implement EHR settings to identify patients with hypertension and provide local, tailored resources and education.

#### Activity 6.2: Work with clinicians, local farmer’s markets, and community partners to explore implementation of fruits and vegetable prescription programs.

#### Activity 6.3: Explore and test innovations to expand use of telehealth including mobile health technology (e.g., smart apps, two-way text messaging, etc.) to promote management of hypertension and high blood cholesterol.

#### Activity 6.4: Explore provision of Medical Nutrition Therapy via telehealth to adults with hypertension and high cholesterol in rural/frontier areas.

# Action Plan and Accountability

This Strategic Plan and accompanying updates are informed by complementary efforts taking place at the state, local, and national levels. This Plan and any updates are intended to address the current and future direction of Nevada’s efforts to promote CVD prevention and management. To continue the HDSP Task Force’s momentum, the following series of implementation steps will take place throughout 2019:

* Convene quarterly HDSP Task Force meetings to discuss statewide efforts to address the burden of CVD and share best practices.
* Engage non-traditional stakeholders to increase access to healthcare and promote self-management of hypertension and high blood cholesterol.
* Facilitate the continued involvement of statewide stakeholders in an advisory capacity, providing guidance and input on the implementation of innovative strategies to prevent and manage CVD in Nevada.
* Identify and connect organizations and individuals committed to addressing the burden of CVD.
* Develop, implement, and evaluate innovative approaches to prevent and manage CVD.
* Forge sustainable, statewide multi-sector partnerships to reduce health disparities and improve the quality of clinical services, especially in relation to heart disease and stroke prevention and care.

1. National Center for Health Statistics. Health, United States, 2016: With Chartbook on Long-term Trends in Health. Hyattsville, MD.2017. [↑](#footnote-ref-1)
2. Office of Analytics. Department of Health and Human Services. Minority Health Report: 2012-2016. Carson City, Nevada e1.0. March 2018. [↑](#footnote-ref-2)
3. Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2017 [↑](#footnote-ref-3)
4. ECHO is a telehealth linkage connecting university-based faculty specialists to primary care providers in rural and under-served areas to extend specialty care to patients with chronic, costly, and complex medical illnesses. [↑](#footnote-ref-4)