

Jack:

Welcome to today's Lunch & Learn Webinar, presented by the Applied Research and Evaluation Branch in the Division for Heart Disease and Stroke Prevention at the Centers for Disease Control and Prevention.

We are fortunate to have an AREB project team with us today to give an in-depth presentation on the Best Practices Guide. As you may know, we initially presented an overview on the launch of the Best Practices Guide during AREB's "Coffee Break" webinar in December, but we had technical issues with the lines getting full and some callers not being able to hear the presentation.

So, back by popular demand, Dr. Nikki Hawkins will present a similar overview, this time going deeper into the content of the guide. Other team members, Lauren Taylor and Aunima Bhuiya, will then give a virtual walk-through of the guide to conclude the presentation.

My name is Jack Chapel and I am also a member of the project team. I'll be serving as today's moderator, and we also have Sharada Shantharam with us to field comments and provide technical support during our session.

Before we begin

**All phones have been placed
in SILENT mode.**

Issues or questions:

- Q & A box on your screen
- Email Sharada at
ktq4@cdc.gov



Jack:

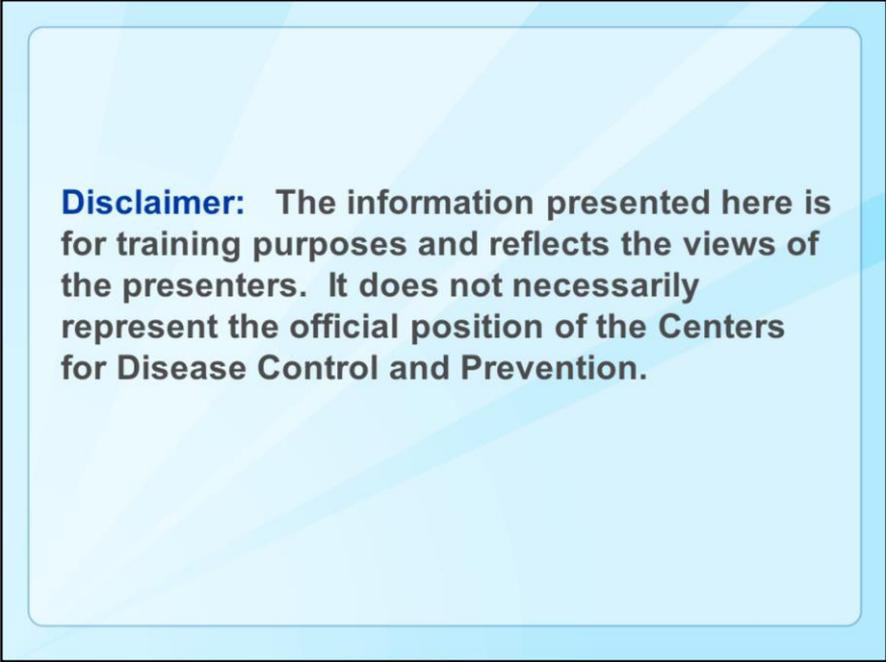
Before we begin we have a few housekeeping items.

All participants have been muted. However, to improve audio quality please mute your phones and microphones now.

If you are having issues with audio or seeing the presentation, please message us using the general chat box, private chat to the host, or send an email to Sharada at ktq4@cdc.gov.

The slides being shown today are not currently available for download, however you will be receiving more information on when and where you can access the slides at the conclusion of the webinar.

If you have questions during the presentation, please type it in the chat box on your screen. We will address questions at the end of the session.



Disclaimer: The information presented here is for training purposes and reflects the views of the presenters. It does not necessarily represent the official position of the Centers for Disease Control and Prevention.

Jack:

Lastly before we begin: the information presented here is for training purposes and reflects the views of the presenters. It does not necessarily represent the official position of the Centers for Disease Control and Prevention.

So, without further delay. Let's get started. **Dr. Hawkins** the floor is yours.

Today's Lunch & Learn Objectives

1. **Background & Development (Nikki)**
2. **Results (Nikki)**
 - Best Practice Strategies & Resources
3. **Demonstration & Walk-Through (Lauren & Aunima)**
 - PDF version
 - HTML, web-based version

Nikki:

Thank you Jack, and thank you all on the phone for joining us today for this 1-hour webinar that focuses, once again, on our best practices guide, or what we affectionately refer to as the “BPG”

The objectives for today's session are to:

First, review the background, development, and goals of the guide;

Second, to highlight the results of our evidence review—and for that we'll go through each of the 8 strategies that are highlighted as “best practices” in this guide.

And, finally Lauren & Aunima will do a live demonstration and walk-through of the guide, showing you how to access both the PDF and web-based versions, and walking you through some of the special features and resources that the guide has to offer.



Background

- ❑ **Heart disease is the leading cause of death in men and women in the United States.**
- ❑ **Each year, CVD claims 830,000+ lives and costs \$320 billion**
- ❑ **Treatments for hypertension and hyperlipidemia are effective and inexpensive.**
- ❑ **The majority do not have these risk factors under control or properly managed.**

As many of you know, heart disease is the leading cause of death in men and women in the United States. It claims over 830,000 lives each year and costs the U.S. economy more than \$320 billion annually in lost productivity and medical care costs. Treatments for hypertension and hyperlipidemia—two key risk factors for heart disease—are widely available, known to be effective, and relatively inexpensive. Despite these available and effective treatments, however, many people don't have these risk factors under control or properly managed. So there's a continued and urgent need to make changes on a large-scale to reduce barriers and prevent the grave costs and consequences of heart disease.



Samuel Siegfried Karl Ritter von Basch invented the first sphygmomanometer in 1881

It's often said that there's a significant lag time—some estimate 17 years or more-- between the discovery of an effective practice and its widespread use in medicine. Our work here in the Applied Research and Evaluation Branch aims to shorten this lag by translating scientific evidence into practical resources and tools that can change practice and, ultimately, save more lives. When we started talking about creating a Best Practices Guide for cardiovascular disease prevention, our primary goal was to produce an informational resource that highlighted some of the best research out there to facilitate--and help speed up--the translation of research findings to practice.

The graphic is a light blue rectangle with a white border. On the left, there are two dark blue vertical panels. The top panel is labeled 'Domain 3: Effective Strategies in Health Care System Interventions' and features a white icon of a hospital building with a cross. The bottom panel is labeled 'Domain 4: Effective Strategies in Community Programs Linked to Clinical Services' and features a white icon of three people in a circle with arrows. To the right of these panels, the text 'Project Goal' is written in a large, bold, dark blue font. Below this, the main goal is stated in a bold, black font. At the bottom right, there is a small asterisked footnote in a smaller font.

Project Goal

To produce a resource guide that summarizes scientific evidence behind effective cardiovascular (CVD) prevention and control strategies that can be implemented in health care systems (domain 3*) and in communities, through community-clinical links (domain 4*).

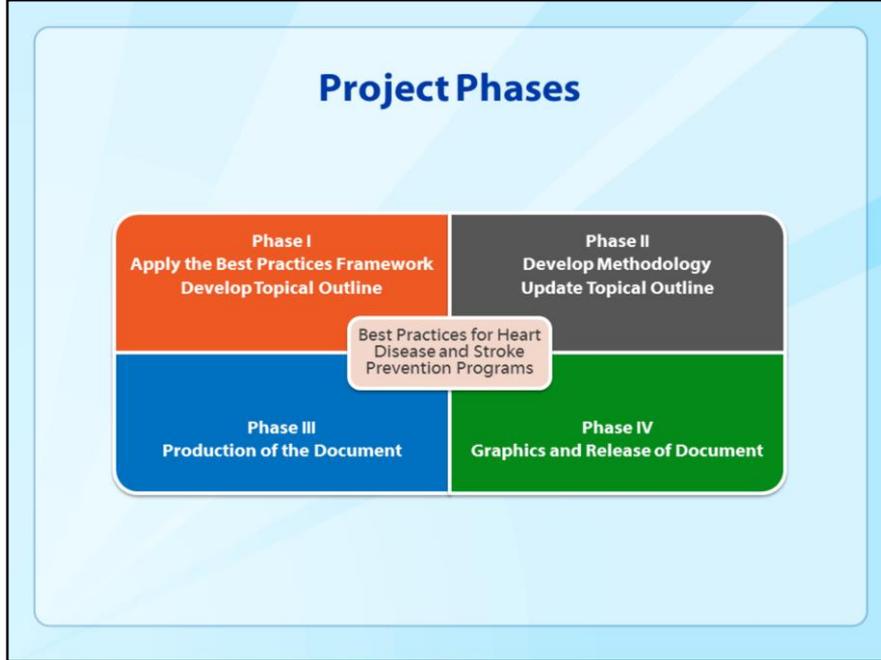
* For more information on CDC's domain 3 and 4 focus areas, see: Bauer UE, Briss PA, Goodman BA, Bowman BA. Prevention of chronic disease in the 21st century: elimination of the leading preventable causes of premature death and disability in the USA. Lancet. 2014;384(9937):45-52.

Our specific project goal was to produce a resource guide that summarizes scientific evidence behind effective CVD prevention and control strategies that can be implemented in health care systems (which is the CDC’s Chronic Disease Prevention Center’s domain 3 focus area) and in community programs that link to clinical services (which is our domain 4 focus area).

Target Audience

- ❑ **Public health practitioners in state and local health departments**
- ❑ **Decision-makers**
- ❑ **Stakeholders interested in implementing strategies to improve cardiovascular health.**

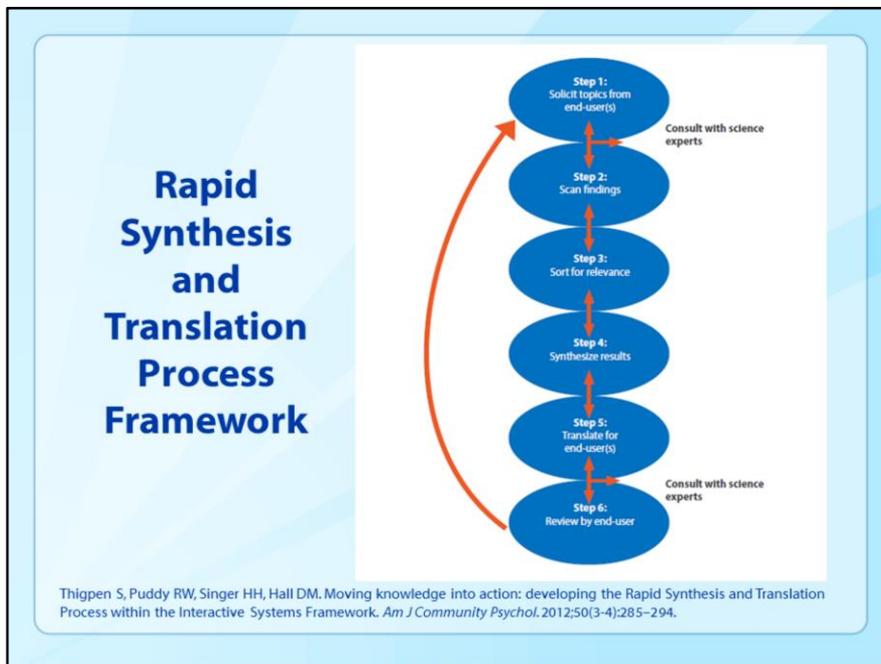
The target audience for the best practices guide is public health practitioners in state and local health departments, decision-makers, and any stakeholders interested in implementing strategies to improve cardiovascular health.



The project was divided into 4 main phases, which you can see here. In the 1st phase, we applied a theoretical framework and developed a topical outline, in phase 2, we developed the methodology that was used to review the topics and get input from reviewers. In Phase 3, we put all the pieces together in the production of the document, and in Phase 4, we focused on the final stages of production, review, and the BPG’s launch on the CDC website.

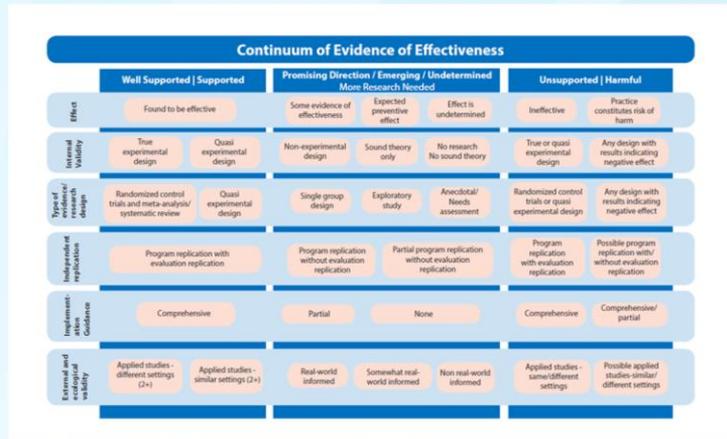


To guide this project, we used the Best Practices framework, which was developed here at CDC and published in *Preventing Chronic Disease* in 2013. According to this framework, “best” practices are those that have both the highest quality of evidence supporting them, which is on the x-axis here, and they've shown a high potential for public health impact (on the y-axis; and conceptualized in terms of effectiveness, reach, feasibility, sustainability, and transferability).



The Rapid Synthesis and Translation Process was also followed to guide the development of the BPG. This conceptual process came out of CDC’s National Center for Injury Prevention and Control and it consists of six fundamental steps for knowledge translation, which roughly occur in the order you see here. You can see from the notes on the right that we consulted with subject matter experts and end users at several places in the process, first in step 1 to solicit effective practices and get input on the content of the guide, and then again in step 6 to review our draft.

Continuum of Evidence of Effectiveness



PuddyRW, Wilkins N. *Understanding Evidence Part 1: Best Available Research Evidence. A Guide to the Continuum of Evidence of Effectiveness.* Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2011.

In developing the BPG, we went through several steps to review and vet the best practice strategies. To assess the quality of the evidence supporting specific strategies, we had a team of reviewers use an interactive tool—that was also developed here at CDC—that’s called the Continuum of Evidence of Effectiveness. That’s what you’re looking at here. To use this tool, a rater answers questions about the entire body of research that’s available on a certain strategy. For example, they answer questions about the demonstrated effectiveness of the strategy, the validity and reliability of findings, whether the strategy has been evaluated multiple times by different groups, and a number of other considerations that you can see on the tabs for each of the horizontal rows in this figure.

Continuum of Evidence of Effectiveness

Continuum of Evidence of Effectiveness							
	Well Supported Supported		Promising Direction / Emerging / Undetermined More Research Needed			Unsupported Harmful	
Effect	Found to be effective		Some evidence of effectiveness	Expected positive effect	Effect is undetermined	Ineffective	Practice constitutes risk of harm
Internal validity	True experimental design	Quasi experimental design	Non-experimental design	Sound theory only	No research No sound theory	True or quasi experimental design	Any design with results indicating negative effect
Type of research design	Randomized control trials and meta-analysis/systematic review	Quasi experimental design	Single group design	Exploratory study	Anecdotal/Needs assessment	Randomized control trials or quasi experimental design	Any design with results indicating negative effect
Independent replications	Program replication with evaluation replication		Program replication without evaluation replication	Partial program replication without evaluation replication		Program replication with evaluation replication	Possible program replication with/without evaluation replication
Implementation guidance	Comprehensive		Partial	None		Comprehensive	Comprehensive/partial
External and ecological validity	Applied studies - different settings (2+)	Applied studies - similar settings (2+)	Real world informed	Somewhat real world informed	Non real-world informed	Applied studies - same/different settings	Possible applied studies - similar/different settings

After answering the series of questions, this tool highlights the results, indicating the strength of the findings in each of these domains. The overarching result categories can be seen at the top and are used to indicate whether the practice is supported, emerging, or unsupported in each of these domains. For our BPG, we included only strategies that were in the supported category for all criteria with the exception of “implementation guidance.” The implementation guidance category basically indicates whether technical guidance for implementation is publicly available. We recognize that implementation guidance is very important and useful, but we didn’t consider it a mandatory prerequisite for consideration in the BPG.

The Best Practices Framework



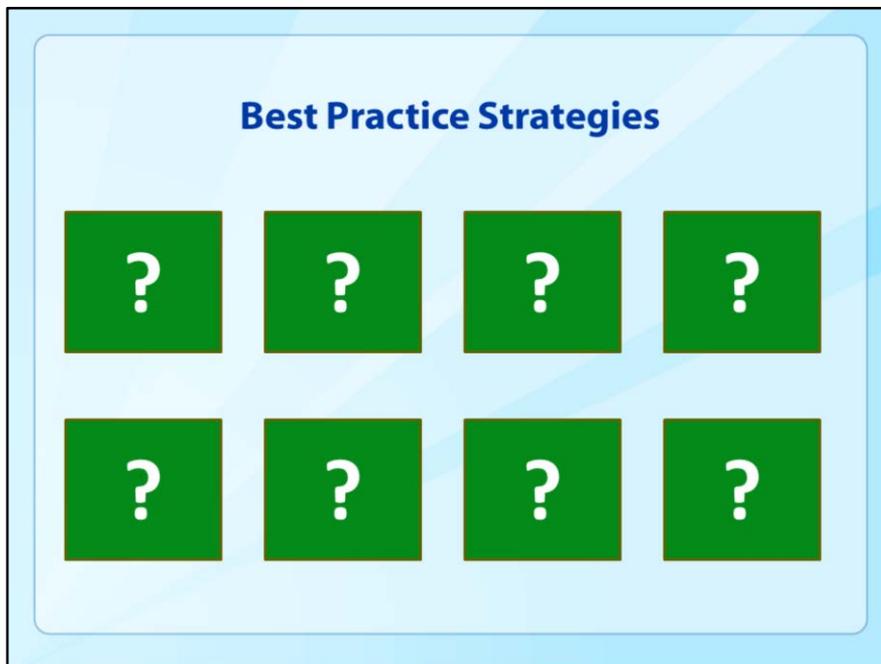
So, the continuum tool that we just discussed nicely assessed the quality of evidence behind the potential strategies...



...But we wanted to go further in addressing the potential for public health impact, especially the reach, feasibility and sustainability of the strategies. So, using the same research base that we used to rate the quality of evidence, we also looked at that evidence for signs of potential public health impact.



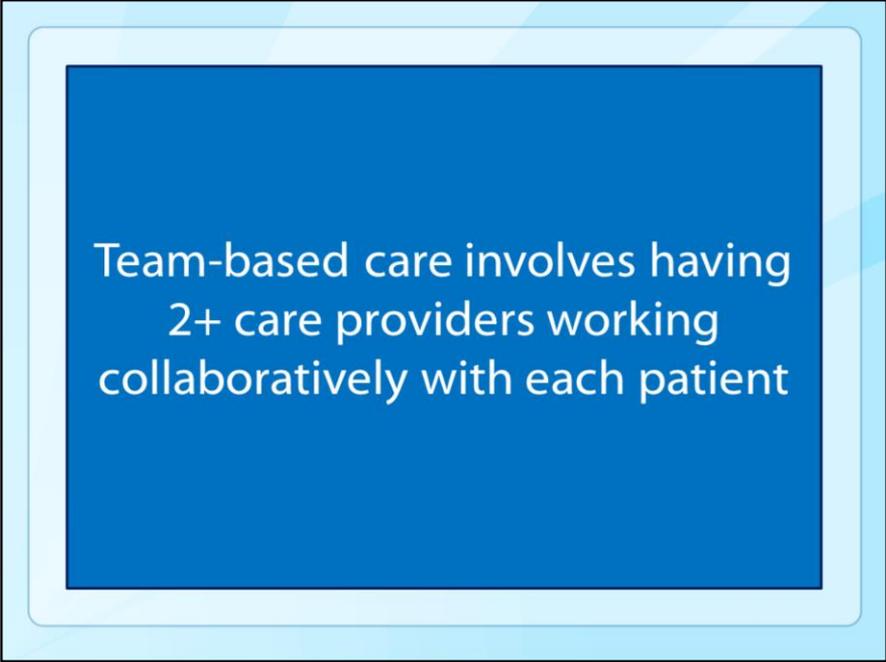
For this dimension, reviewers assessed the evidence for: 1. health impact—which refers to the strategy’s ability to improve blood pressure or cholesterol levels, 2. health disparity impact—which gets at "reach" and is a measure of whether the strategies have been found effective with diverse or low-resource populations, and 3. economic impact—which gets at feasibility & sustainability and is a measure of whether there's evidence that the strategy demonstrates cost-effectiveness or any return on investment.



So, based on the process and methods for reviewing the literature that we just went through, we identified a series of 8 “Best Practice” strategies for CVD prevention. And I’ll now go through each of them.



1. These are in no particular order, but the first one we'll talk about is "Team Based Care"

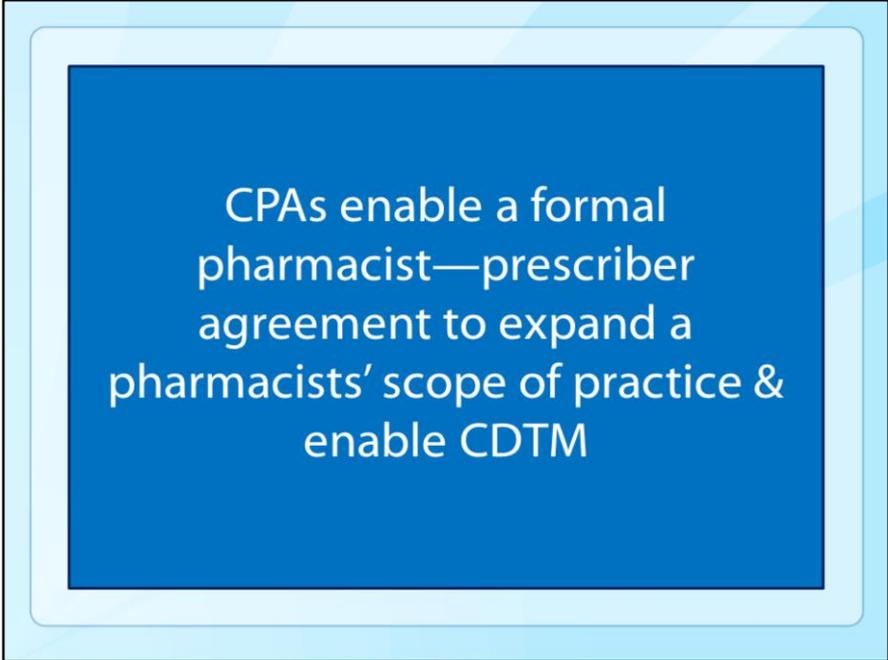


Team-based care involves having
2+ care providers working
collaboratively with each patient

“Team Based Care” is defined as having 2 or more care providers working collaboratively with each patient to address CVD-related issues. The teams could involve primary care providers, nurses, pharmacists, dietitians, and host of other specialists, all working together to educate patients, identify risk factors, prescribe and modify treatments, and maintain an ongoing dialog with patients about their health and their care from a variety of perspectives.



The second strategy involves pharmacists using collaborative practice agreements (or CPAs) to enable collaborative drug therapy management (or CDTM).

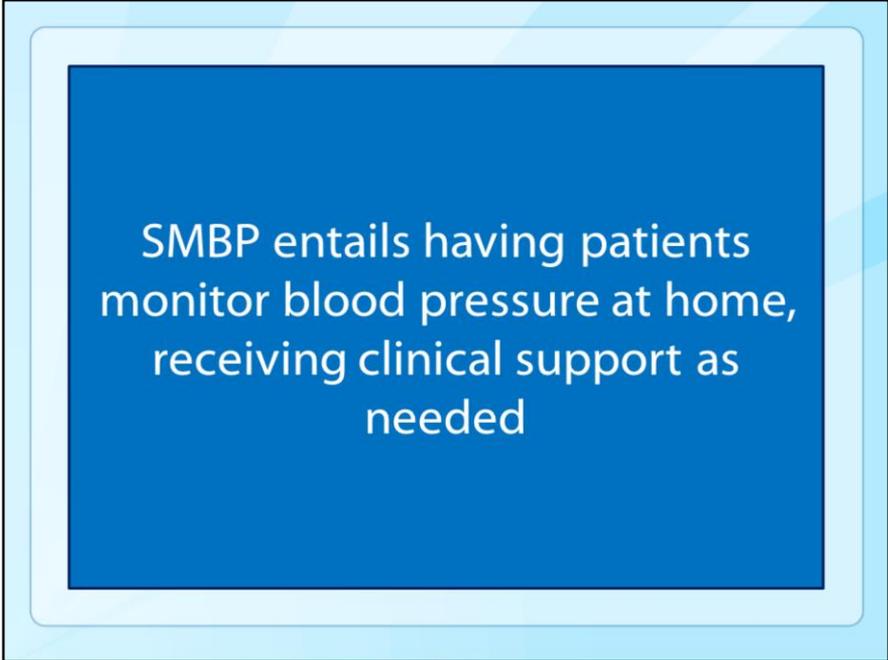


CPAs enable a formal
pharmacist—prescriber
agreement to expand a
pharmacists' scope of practice &
enable CDTM

CPAs allow for a formal partnership between pharmacists and prescribers to expand the pharmacists' scope of practice. This agreement enables a pharmacist to perform drug therapy management, consisting of more in-depth patient assessments, counseling, and referrals; ordering laboratory tests; administering drugs; and selecting, initiating, monitoring, and adjusting drug regimens as needed. CDTM has been found effective in terms of both patient health outcomes and reducing costs.



The next strategy is “Self-Measured Blood Pressure Monitoring (or SMBP) with Clinical Support”



SMBP entails having patients
monitor blood pressure at home,
receiving clinical support as
needed

SMBP entails having patients monitor and record their own blood pressure at home, receiving clinical support as needed. Clinical help can take the form of 1:1 counseling, telephone or web-based support tools, patient education, or a variety of other arrangements, but the main idea here is to have patients using a personal device regularly and staying on top of their blood pressure readings outside of the clinical setting.



The next strategy is “Self-Management Support and Education,” which is similar to SMBP but involves support and education for self-management in a broader sense.

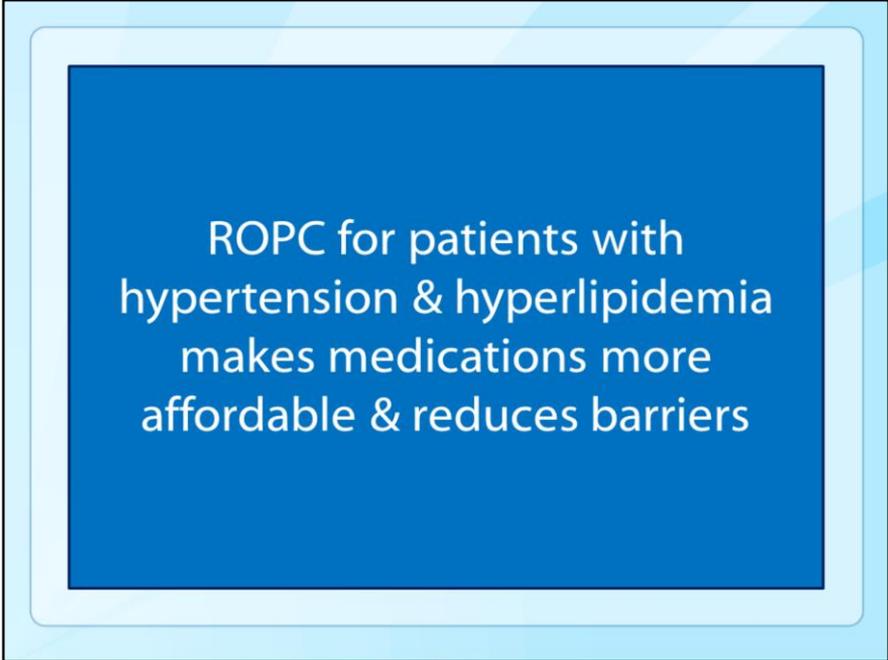


Self-management support & education from providers improves knowledge, self-efficacy, and medication adherence

Self-management support & education has been shown to improve patients' knowledge about their condition, self-efficacy for managing symptoms and risk factors, and it improves medication adherence. This strategy can accompany the previous strategy, SMBP, but it's unique in the approach it takes to educate, support, and empower patients to manage their chronic conditions to the best of their abilities. It's especially helpful for those who are managing multiple chronic conditions, which is quite common in an older population.



The next strategy is “Reducing Out-of-Pocket Costs for Medications” or ROPC for short.

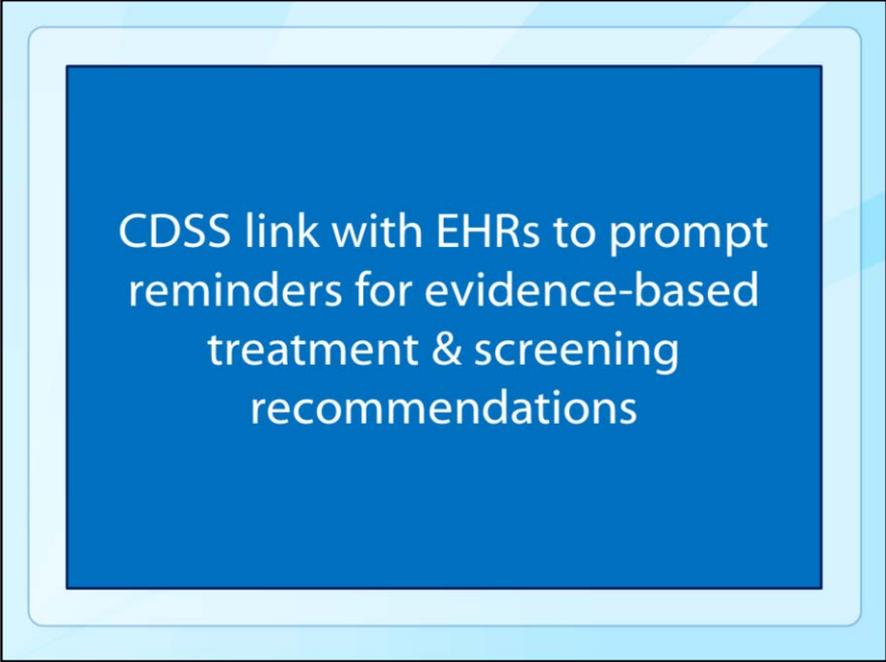


ROPC for patients with
hypertension & hyperlipidemia
makes medications more
affordable & reduces barriers

Reducing costs for patients with hypertension & hyperlipidemia involves program and policy changes that make medications more affordable. As you'd expect, this can significantly increase rates of medication adherence. Logistically, experts recommend that this be done through providing new or expanded health care coverage and by lowering or eliminating copayments and deductibles for medications.



Our next strategy is “Implementing Clinical Decision Support Systems” (or CDSS)

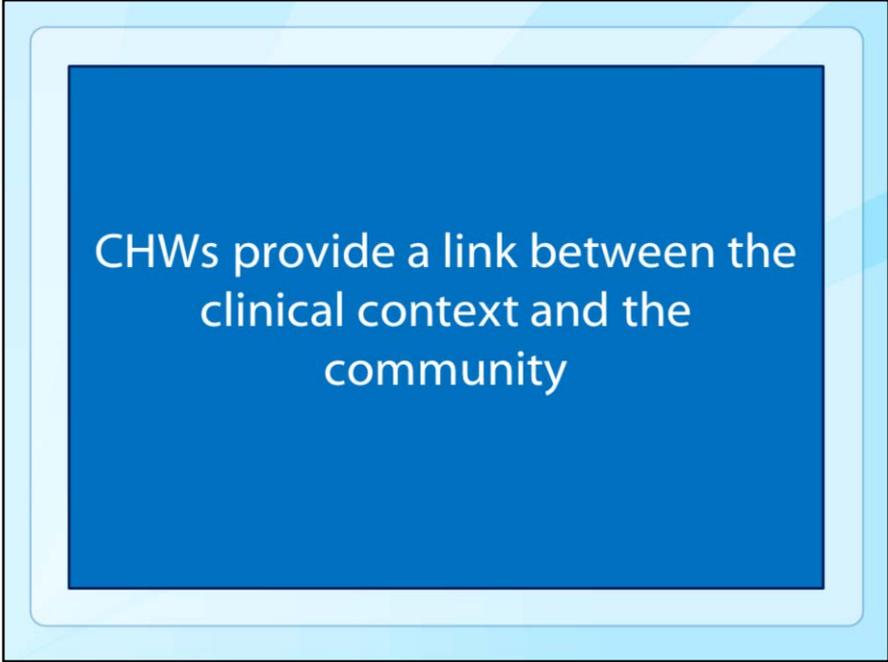


CDSS link with EHRs to prompt
reminders for evidence-based
treatment & screening
recommendations

CDS systems are computer-based programs that link with a patient's electronic health record to provide personalized prompts and reminders at the point of care. For CVD, they can be used to flag cases of hypertension or hyperlipidemia, and to remind providers to recommend screening, provide information on treatment protocols, ask about medication adherence, and provide recommendations for health behavior changes.



Our next to last strategy is “Integrating Community Health Workers onto Clinical Care Teams”

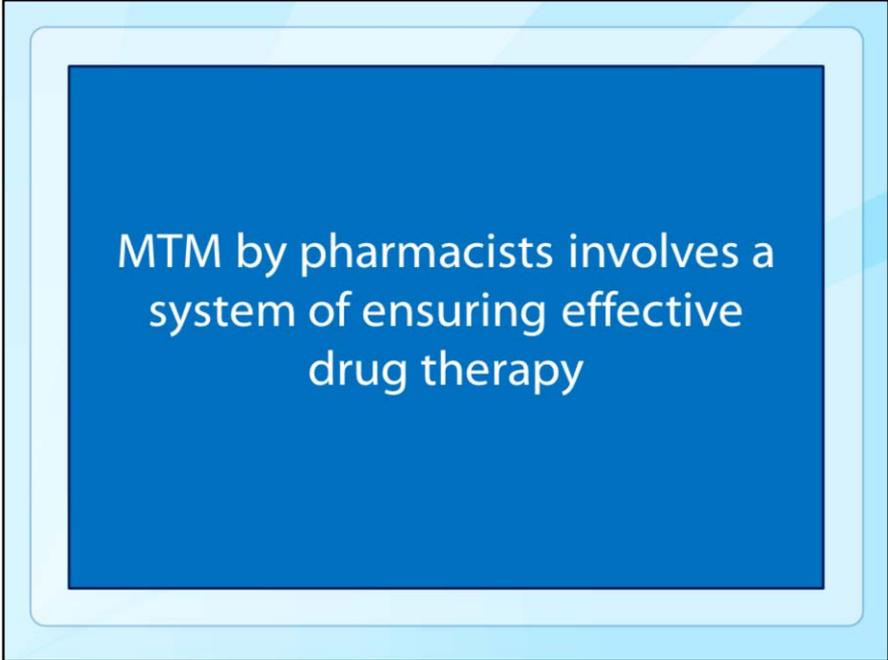


CHWs provide a link between the
clinical context and the
community

Community Health Workers provide an important link between the clinical context and the community. This link can improve the chances that patients will use health-related services and it can improve the quality and cultural competence of clinical care. Other benefits include improvements in patients' understanding of their diagnosis and the prescribed treatments, improved medication adherence, and lowered blood pressure and cholesterol levels.



And, our last strategy is another one involving pharmacists. This time highlighting “Medication Therapy Management” or MTM for short



MTM by pharmacists involves a system of ensuring effective drug therapy

MTM by pharmacists involves a system, or series of steps, done to ensure comprehensive and effective drug therapy. Within the context of CVD, MTM centers on identifying uncontrolled hypertension, educating patients on cardiovascular disease and the related medication therapies, and advising patients on health behaviors for better health outcomes. It's especially helpful for patients with multiple chronic conditions, complex medication therapies, high prescription costs, and when multiple prescribers are caring for the same patient.

Best Practice Strategies

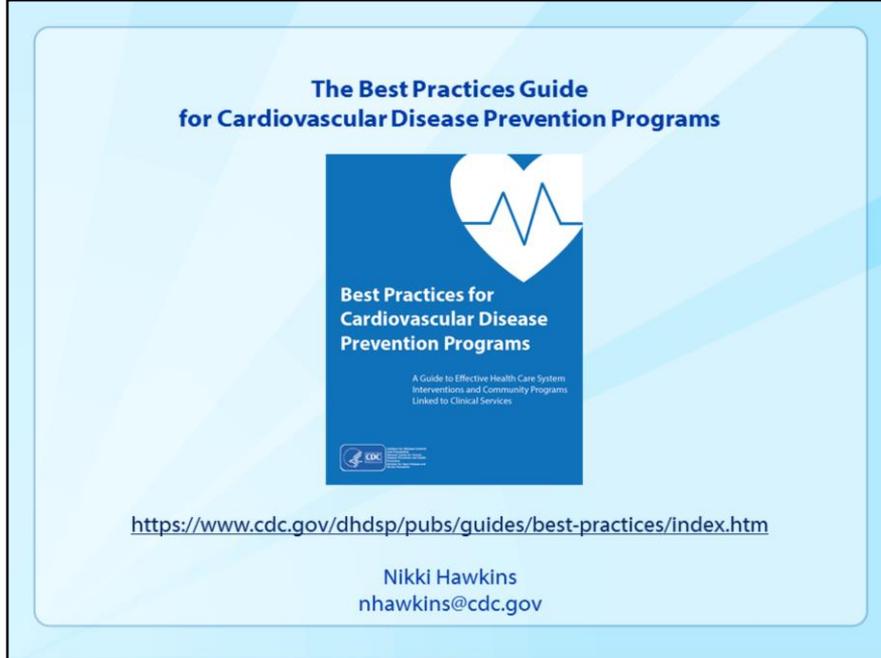
Health Care Systems Interventions (Domain 3)

- Team-based care
- Pharmacy collaborative practice agreements (CPAs)
- Self-measured blood pressure (SMBP) with support
- Self-management support and education
- Reduced out-of-pocket costs for medication
- Clinical decision support systems (CDSS)

Community-Clinical Linkages (Domain 4)

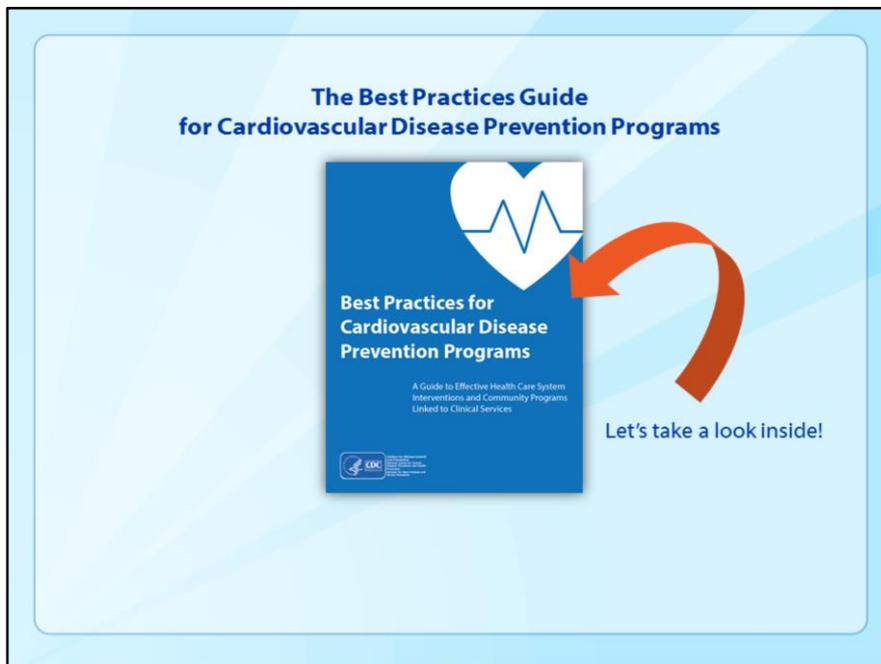
- Community health workers (CHWs)
- Medication therapy management (MTM)

This is the complete list of the strategies that we just covered and how they fit into the two different domains. This list could change or grow if/when we do an updated version of the guide but for now, these are the ones we've included.



That's it for the background and overview of the strategies in our BPG. You can find the guide on the CDC website at this link, and Aunima will soon walk you through navigating to it from the DHDSP website. Of course, if you have any questions or suggestions, you can reach out to me at nhawkins@cdc.gov or anyone else on the project team.

I will now turn it over to Lauren to walk you through the pages of the guide itself.



Lauren:

Thank you Nikki. Hello everyone! On the next couple of slides I will be doing a walkthrough of one of the BPG 8 strategies. Specifically, we will be looking at Promoting Team-Based Care to Improve High Blood Pressure Control within Domain 3, which focuses on Health Care Systems Interventions, so without further delay, let's dive in!



During this walkthrough I've provided some screenshots to give an idea of how our summaries look for each strategy.

Starting at the top of each strategy you will notice that a breadcrumb trail exists (click). This trail allows the reader at any point during the PDF to be aware of what strategy they are currently viewing. As you can see (click), the first strategy icon representing team-based care is highlighted in blue. As the reader moves throughout the document, the corresponding highlighted icon will change to reflect the strategy being viewed.

Next, we have a brief overview of the strategy (click) which defines what team-based care is and expounds on what team-based care is within the context of cardiovascular disease prevention.

Underneath the brief overview, you will see an orange box to the left (click). Here, you will find a summary of the evidence examined during the creation of the BPG. This box highlights that team-based care is cost-effective and is impactful in diverse populations in various settings.

Lastly, we give specific evidence ratings for effectiveness and public health impact

(click). The blue and green rating icons (which looks like a dial) indicate whether the respective subcategory is supported, emerging, or unsupported. For team-based care, the rated strength of research evidence, relating to the effectiveness and impact subcategories, were all supported, as indicated by the completely filled rating symbols.

PDF Walkthrough: Team Based Care

Domain 3 Health Care System Interventions
Team-Based Care

Evidence of Effectiveness

The evidence base for implementing team-based care in health care systems and practices is very strong. Solid evidence exists that this strategy addresses several outcomes, with studies demonstrating internal and external validity. This strategy has also been independently validated, which shows reliability of impact. Several randomized controlled trials, which are often considered the gold standard of research, have been conducted and show positive results from using multidisciplinary teams as a way to improve hypertension control. Various organizations, such as the American Medical Association and the Agency for Healthcare Research and Quality (AHRQ), have developed guidelines to help health care systems and practices implement this strategy as part of their policies and protocols.

Evidence of Impact

Health Impact	Health Disparity Impact	Economic Impact
<p>A systematic review by the Community Research Centers Task Force concluded that team-based care can lead to significantly improved hypertension control, lowered systolic and diastolic blood pressure levels (overall mean reduction was 5.4 mmHg and 3.6 mmHg, respectively), and improved patient adherence to hypertension medication.¹</p> <p>The evidence base for implementing team-based care in health care systems and practices is very strong.</p>	<p>Team-based care has been found to be effective when used among diverse patient populations, including those with members of different racial and ethnic groups (e.g., whites, African American) and among patients with multiple health conditions.</p> <p>Evidence also exists that this strategy is effective among low-income populations. Additional research is needed to examine effectiveness among populations that are primarily Hispanic and in communities with other minority populations.²</p>	<p>Team-based care has proven to be cost effective. The median total cost for providing team-based care for hypertension control was found to be \$395 per patient per year. The median cost per quality-adjusted life year (QALY) gained over 30 years was either \$12,511 or \$12,135, depending on the QALY conversion method used.³ Both estimates were well below the commonly used and conservative cost effectiveness threshold of \$50,000 per QALY.</p> <p>Researcher modeled the health and economic impact of nationwide adoption of team-based care for hypertension over 10 years and estimated net cost savings to Medicare of \$1.8 billion (2012 US dollars) over this period. This report also estimates an overall national savings of \$2.3 billion in avoided disease costs, which offsets an estimated \$2.3 billion cost of using this intervention in the health care system. Costs for patient time over this period are estimated at \$1.8 billion, but are largely offset by an estimated \$1.1 billion in productivity gains.⁴</p>

Best Practices Guide for Cardiovascular Disease Prevention Programs

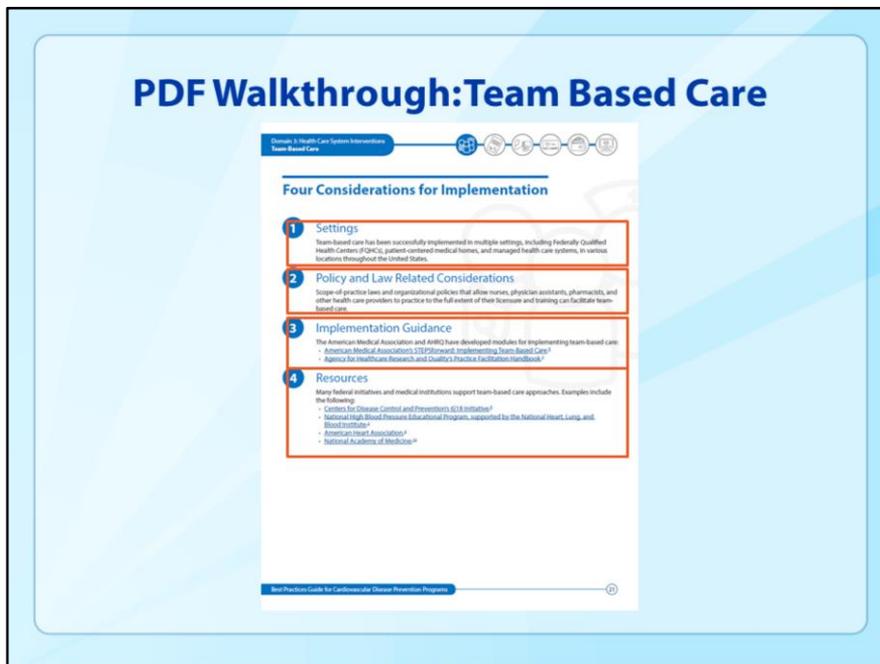
On the 2nd page is where we explain the ratings shown on the previous page. Specifically, this is where we go into a little more detail about the strength of evidence behind team-based care (click), and what the evidence says about team-based care's ability to make a public health impact through addressing health, health disparity, and economic factors, which is shown here (click).

PDF Walkthrough: Team Based Care



The 3rd page is dedicated to Stories from the Field, in which we highlight a specific setting where the strategy has been implemented with success. For each story, we provide follow-up or contact information where readers can go to learn more. For Team-Based Care we highlighted WinMed Health Services, (click) a 2014 Million Hearts Hypertension Control Champion, who incorporated team-based care and achieved a 7% increase in hypertension control among its population from 2013-2014.

PDF Walkthrough: Team Based Care



In line with our hopes that the BPG will actually facilitate the implementation of effective strategies, on the last page of each summary, we offer information in four areas that are relevant to implementation. First (click), we describe settings where the strategy has already been implemented successfully (such as Federally Qualified Health Centers or retail pharmacies). Second (click), we mention key policy & law-related considerations that could be important to address before implementation (such as scope of practice laws, or policies around reimbursement for various services). Third (click), we provide links to implementation guidance where you can find publicly-available resources and toolkits to assist with implementing each specific strategy (such as the modules developed by the AMA and AHRQ for implementing team-based care). And, finally (click), we offer an "other resources" section that provides links to federal and organizational guidelines or statements of support for implementing each of the strategies.

Summary of Effective CVD Prevention Strategies

Strategy	Evidence of Effectiveness Dimensions						Evidence of Impact		
	Effect	Internal Validity	Research Design	Independent Application	Implementation Fidelity	Ecological Validity	Health Impact	Disparity Impact	Economic Impact
Team-Based Care to Improve Hypertension Control									
Pharmacy Collaborative Practice Agreements to Enable Collaborative Drug Therapy Management									
Self-Measured Blood Pressure Monitoring With Clinical Support									
Self-Management Support and Education									
Reducing Out-of-Pocket Costs for Medications									
Implementing Clinical Decision Support Systems									
Using Community Health Workers on Clinical Care Teams and in the Community									
Community Pharmacists and Medication Therapy Management									

Well supported/Supported
 Promising/Emerging
 Unsupported/Harmful
 Supported
 Moderate
 Insufficient

At the end of the best practices guide document, we've included this strategy summary table that provides a way to quickly look and compare the ratings for each strategy. If you remember, ratings like these were shown on the first page of the team-based care strategy, which is also shown here (click), along with the other 7 strategies covered in the BPG. You will note that the strategies have been separated by their respective domain (click) and the ratings have been separated by the effectiveness and impact dimensions (click). Overall, this table is a great way for you to get a full snapshot of the BPG strategies to implement as you see fit.

At this time, I will pass it off to Aunima to continue the remainder of our presentation.

At this time, we will now do a live walkthrough of the BPG website

The screenshot shows a CDC webpage with a left-hand navigation menu containing links for 'About Us', 'Programs', 'Data and Maps', 'Publications & Research', 'Evaluation Resources', 'Data & Statistics', 'Grantee Information', and 'Educational Materials'. The main content area features a title 'Promoting Team-Based Care to Improve High Blood Pressure Control' with social media icons and a 'Download the guide' button. Below this is a paragraph explaining that team-based care is a strategy to enhance patient care by having two or more health care providers working collaboratively. A sub-section titled 'Evidence of Effectiveness' includes a table with columns for 'Evidence of Effectiveness', 'Evidence of Impact', and 'Stories From the Field'. The 'Evidence of Effectiveness' section contains a detailed paragraph about the evidence base for implementing team-based care, mentioning that it has been independently replicated and that several randomized controlled trials have been conducted. A legend at the bottom of this section defines symbols for 'Effect', 'Implementation Guidance', 'Research Design', 'Internal Validity', 'Independent Replication', 'External & Ecological Validity', 'Legend: Not assessed', 'Assessed', and 'Assessed & Ranked'.

Aunima:

Thanks Lauren. We'll be switching over to share our screen with the webpage momentarily, please let us know in the comment box if you don't see it. The guide is housed through a couple of clicks from the Division for Heart Disease and Stroke Prevention webpage. If we scroll down to Publications & Research, and then if we click on Guides. You will see two options, either click on the tab or clicking the Best Practices Guide link on the right-side. Alternatively, you can google search keywords such as the Best Practices Guide CDC.

We're now on the landing page, where this page provides: a brief description of the guide, a link to learn more about the development of the guide, a link to download the PDF version, and links to the 8 strategies below.

Let's take a look at one of the strategies, such as medication therapy management. Going across from the left-side first, you can navigate to other parts of the guide, such as more About the Guide, and to the other strategies.

The actual content is the same across the website and the PDF version. Each page

provides a brief summary of the strategy, a link to download the individual strategy pages, and 3 tabs to describe the evidence of effectiveness, evidence of impact, and implementation considerations. We teased out Stories from the Field to highlight the strategy in practice, with a link to learn more.

At this time I will pass it back off to Jack.

AHA's State Cardiovascular Health Programs: A Guide to Core Infrastructure, Activities and Resources

Purpose: To provide recommendations for state health departments for essential core infrastructure and key cardiovascular health activities as well as to highlight potential alternative funding streams.

NOT Included: Detailed information on the evidence behind strategies/interventions nor implementation information.

Location:

Full report:

http://www.heart.org/idc/groups/heart-public/@wcm/@global/documents/downloadable/ucm_498551.pdf

Policy in Brief:

http://www.heart.org/idc/groups/heart-public/@wcm/@global/documents/downloadable/ucm_498552.pdf

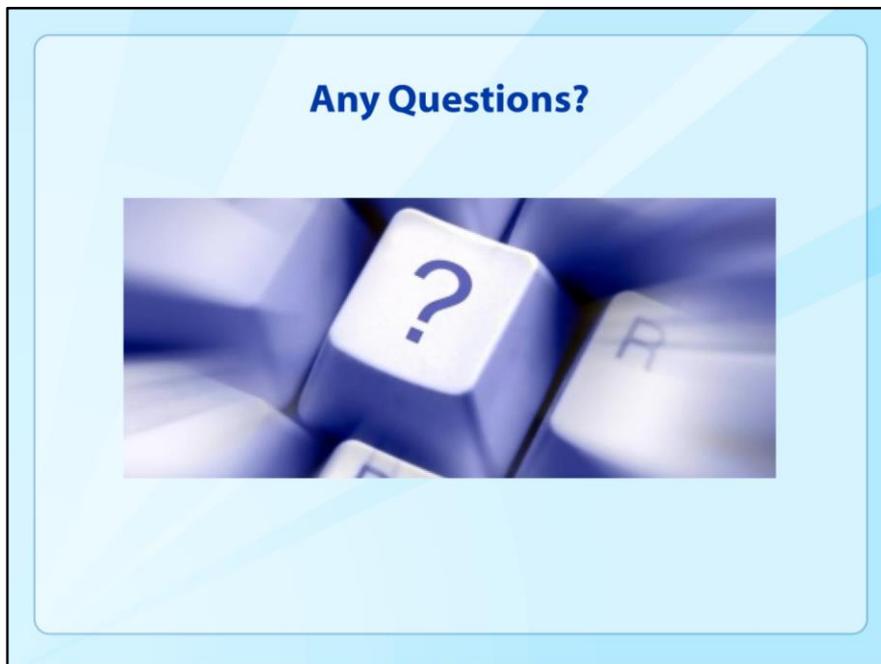
Point of Contact: Madeleine Konig (Madeleine.Konig@heart.org)

Thank you Aunima, and thanks again Nikki and Lauren.

Now, if you love everything you've seen here but still want more—especially dealing with core infrastructure and alternative funding streams for best practice strategies--the last thing I want to mention is a quick overview of a different but similar document our colleagues at the American Heart Association have recently released. We've worked collaboratively on the development of these two products and we wanted to put in a plug for those interested to go and learn more.

While our guide highlights evidence and resources for 8 specific best practice strategies, the AHA guide provides recommendations for essential core infrastructure at the state level and it highlights potential funding streams for implementation.

You can see the websites here and the point of contact, Madeleine Konig, if you'd like more information.



At this time, we'll take any questions that we've received through the chat box.

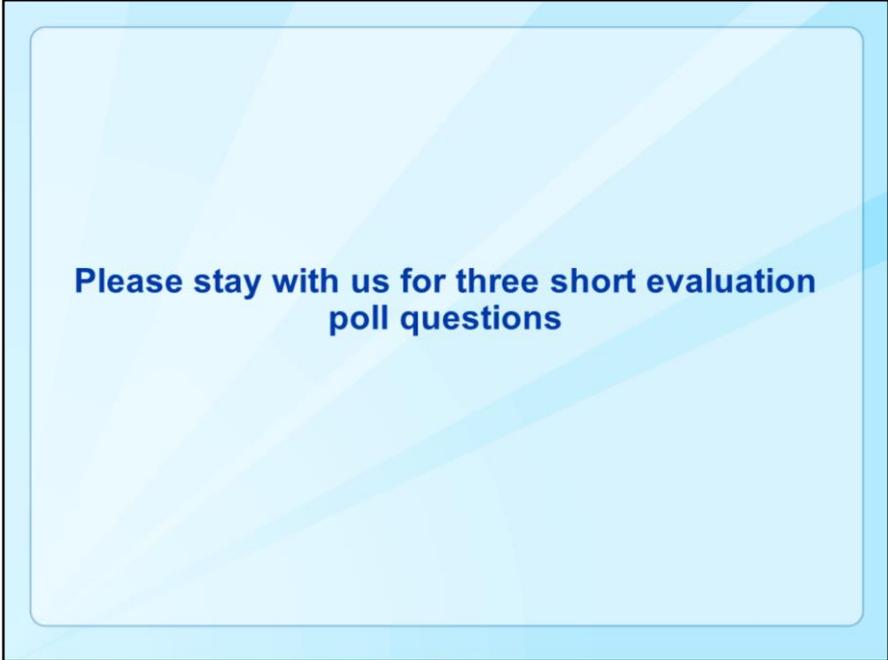
3 MOCK QUESTIONS:

1. If a strategy isn't included here, what does that mean?

As I described before, we went through a pretty stringent process to identify and review strategies before settling on the 8 that are highlighted here. If there's a strategy that you know of that didn't make it on this list, it doesn't mean the strategy isn't effective; it may just be that the strategy didn't fit within our scope (domains 3 & 4); it didn't have quite enough evidence yet, or that the evidence is limited and it didn't meet our threshold for selection. Things are always changing and new evidence pops up all the time, so we'd expect to see more promising strategies show up on this list in a few years from now if we were to go through this process again.

2. Should the best practices guide be considered official guidance for CDC funding?

No, the best practices guide is NOT considered official guidance but rather an informational resource that simply reinforces strategies that the division is already prioritizing. There's no immediate effect on current reporting requirements for CDC funding or anything like that. It is just a translational and informational resource.



**Please stay with us for three short evaluation
poll questions**

Please stay with us a few poll questions.

The level of information was:

Too basic
About right
Beyond my needs

**This webinar was more helpful to me than the previous BPG webinar held in
December (if attended).**

Yes
Somewhat
A little
No not at all

Overall, this webinar was worthwhile for me.

Yes, very worthwhile
Somewhat
A little
No not at all

Additionally, please feel free to provide more descriptive feedback in the chat box or by sending a direct email to Dr. Hawkins at nhawkins@cdc.gov.

Reminders!

All sessions are archived and
the slides and script can be accessed at:

<http://www.cdc.gov/dhdsp/pubs/podcasts.htm>

Slides will also be posted to NACCD "Off the Cuff"
website at:

<http://www.chronicdisease.org/page/OTC>

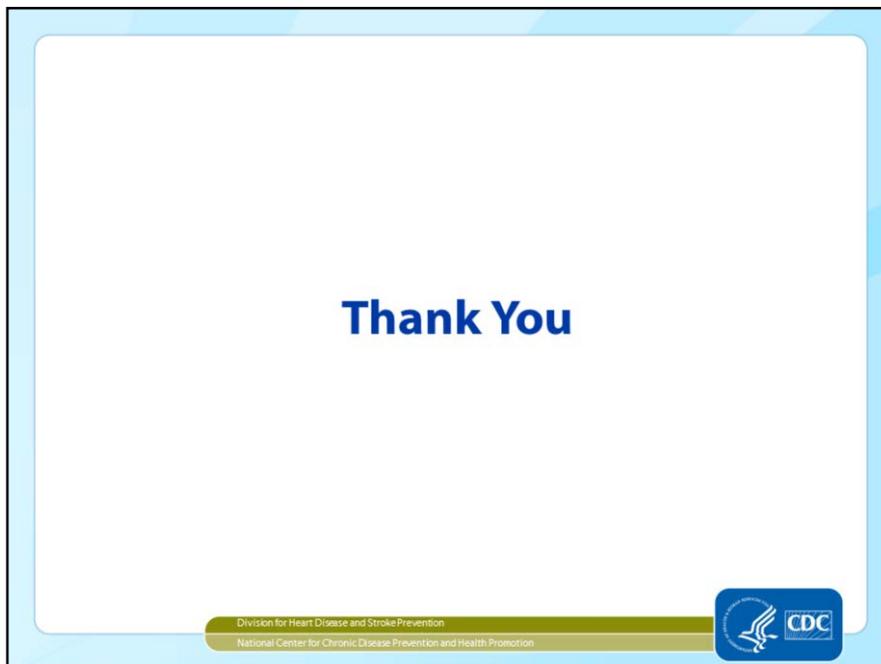
If you have any questions or comments please send
an email to:

nhawkins@cdc.gov

All sessions are archived and the slides and script can be accessed at our Division website. Today's slides will be available in 2-3 weeks.

Additionally, this webinar will also be posted to the NACDD Off the Cuff website.

If you have any questions or comments regarding this presentation, please feel free to send Dr. Hawkins an email at nhawkins@cdc.gov.



That concludes today's webinar. Thank you for joining us. Have a terrific day everyone.