

# Check. Change. *Control.*

## *Connecting Communities and Care*



Connecting Communities and Care

Kaiser Permanente is a proud supporter of the American Heart Association's Connecting Communities and Care initiative to reduce hypertension in America's African-American communities.



# Background

## → Check It. Change It.

Check It. Change It.\* launched in Durham County, N.C. to help a targeted group (~76% African-American) maintain healthy blood pressure. Participants used AHA's web tool [Heart360®](#) to track their BP with health mentoring and guidance from physician assistants as needed.

*In 6 months:*

Mean overall systolic BP

 **4.7 mm Hg**

Rates of achieving target BP control (<140/90 mm Hg)

 **12%**

69% reached their BP target or decreased systolic BP by

 **10 mm Hg**

**The study demonstrated that this type of program can improve BP within a diverse or high-risk community.**

\*Check It, Change It was developed through a collaboration of the American Heart Association and Durham Health Innovations. Novartis Pharmaceuticals Corporation (NPC) provided the full funding for this initiative and is recognized for their participation and support.



Check.  
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Control.™

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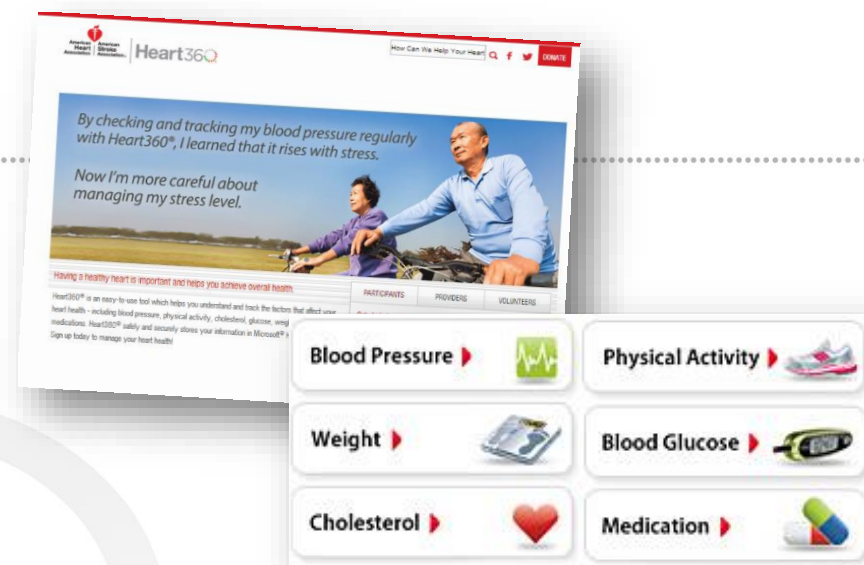


Connecting Communities and Care

# Background

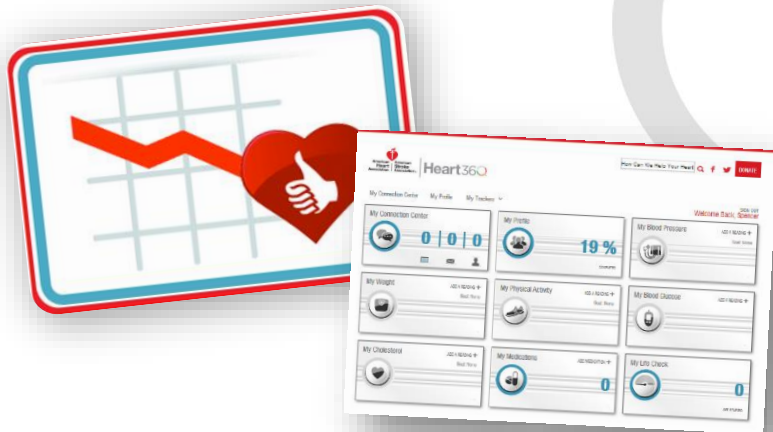
## ➔ Check. Change. *Control.*

As a result of the positive Check It. Change It. results, the AHA launched Check. Change. *Control.* throughout the U.S., a community based program encouraging participants to check their blood pressure at least 8 times in 4 consecutive months with support from a Volunteer Health Mentor.



## ➔ Findings

A 7-month pilot found that systolic BP decreased by a mean of -7.5 mm Hg and diastolic BP by -3.3 mm Hg among all participants (n=4069)



# Background

## **Check. Change. *Control. Connecting Communities and Care***

In an effort to scale the positive results from Check It. Change It. and Check. Change. *Control*, Kaiser Permanente and AHA are coming together to launch Check. Change. *Control. Connecting Communities and Care*.

### GOAL:

Create a systematic linkage between community and clinical settings to eliminate disparities in BP control in African-Americans.

### SUCCESS METRIC:

65% of the program's African-American participants reach BP control (<140/90 mm Hg or the target set by the participants' physicians)



# Target Audience

## → Primary

Adults ages 35–59; inclusive of diverse, ethnic segments; diagnosed with hypertension, who are uncontrolled or clinically defined as having blood pressure numbers not in a healthy range.

## → Secondary

All adults diagnosed with hypertension, who are uncontrolled or clinically defined as having blood pressure numbers not in a healthy range.

**NOTE:** Though this is the AHA's target audience, we encourage anyone to participate in the program regardless of their BP status, age, race and ethnicity.



# Programs

## ➔ **Check. Change. *Control.* Connecting Communities and Care** is guided by several of the American Heart Association's programs:

- **The Guideline Advantage** quality improvement program uses data from electronic health records (EHRs) or health technology platforms to measure adherence to evidence-based guidelines and support population health management.
- The **Check. Change. *Control.*** Community Blood Pressure Program involves continual self-monitoring and tracking blood pressure readings at home or in settings outside healthcare offices, with social support and accountability from a volunteer health mentor.
- **EmPowered To Serve** (ETS) is a national, strategic initiative in which the AHA partners with faith-based organizations, urban/affordable housing and strategic alliances to improve health outcomes in multicultural communities. More than 700,000 people have participated in ETS programs and more than 40,000 Power Ambassadors are raising awareness of cardiovascular disease and stroke warning signs and blood pressure management in their communities.

# Program Participants



**Faith-Based Organizations** interested in helping their congregation tackle the nation's silent killer



**Clinic Staff** who treat individuals with high BP (cardiologists, PCPs, RNs, NPs, PAs)



Program  
Participants

**Worksites** interested in helping employees manage their BP



**Other Community Organizations** that want to help members manage their BP (fitness centers, social clubs, etc.)





# How Does It Work?

➔ Once a clinic, worksite, faith-based organization or other community setting determines they want to implement Check. Change. *Control*. *Connecting Communities and Care*, they complete the following steps (explained in the [Digital Resource Center](#)):

- 1 Set Goals
- 2 Select Your Measurement and Reporting Options
- 3 Recruit
- 4 Train
- 5 Start

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**For More Information Visit:**  
**<http://connectingcommunities.heart.org/>**



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Connecting Communities and Care

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