Constellation
Quality Health

Constellation Regional Collaborative

Improving Heart Health in the Southeast

www.constellationqualityhealth.org

5-Year CDC Cooperative Agreement

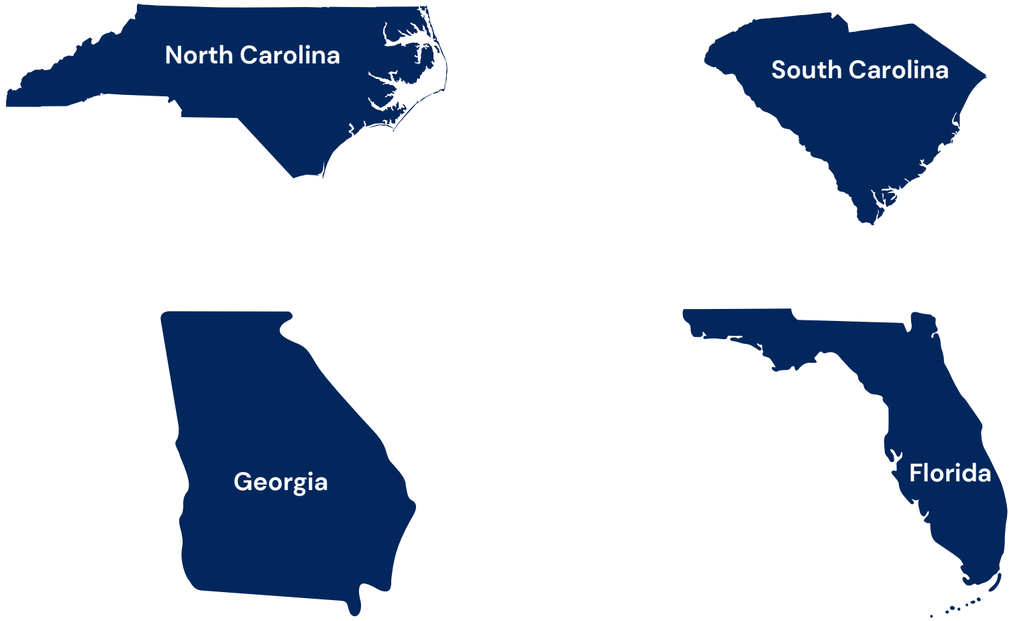
Innovative Cardiovascular Health Program

Constellation Quality Health

To advance cardiovascular health across the Southeast. This work focuses on:

- Addressing cardiovascular health disparities
- Improving outcomes for hypertension, cardiovascular disease, hyperlipidemia, and stroke
- Advance equity-focused interventions for priority populations to prevent, control, and manage cardiovascular risks

Efforts support communities in:



Our Aim

Constellation Quality Health

CDC Strategy 1

Track and Monitor Clinical Measures Shown to Improve Health and Wellness, and Health Care Quality Within Approved Populations of Focus with Hypertension and High Cholesterol.

CDC Strategy 2

Implement Team-Based Care to Prevent, Detect, Control, and Manage Hypertension and High Cholesterol Within Approved Populations of Focus.

CDC Strategy 3

Link Community Resources and Clinical Services that Support Comprehensive Bidirectional Referral and Follow-Up Systems Aimed at Mitigating Social Services and Support Barriers for Optimal Health Outcomes Within Approved Populations of Focus.

Priority Population

Adults age 18+

At risk for or diagnosed with hypertension or cardiovascular disease

Residing in designated priority counties with a crude hypertension prevalence ≥53%

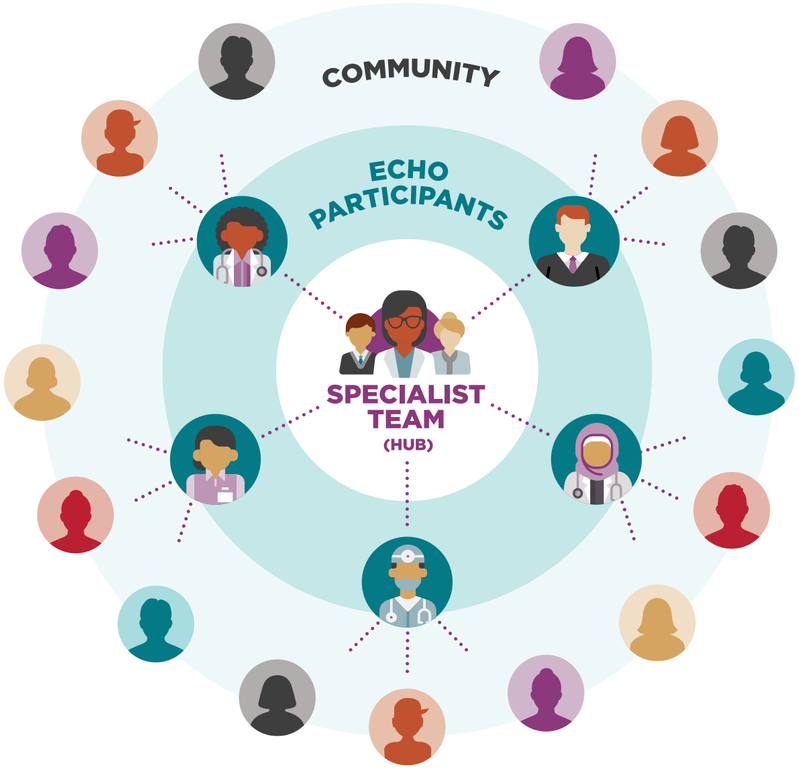
Constellation Regional Collaborative

Program Initiatives

Constellation Quality Health

- Hypertension and Cardiovascular Disease Interdisciplinary ECHO Series (IES)
- Constellation Regional Learning Collaborative (CRLC)
- In-Clinic Pharmacist Pilot (ICPP)
- Constellation Community Care Hub (CCCH)

Hypertension and Cardiovascular Disease Interdisciplinary ECHO Series(IES)



Launched in June 2024, the series is founded on the **Project ECHO® model, developed at the University of New Mexico Health Sciences Center**. IES offers solutions to resistant and complex HTN and CVD cases for primary care providers and community-based organizations, guided by recommendations from clinical and community subject matter experts (SMEs).

- Reoccurring monthly, 1-hour sessions
- "All teach, All Learn"
- Free CEUs credits are offered to participants*
- Community-Clinical Linkages

2026 SERIES STARTS JANUARY WITH NEW SPECIALTY TRACKS

* This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Southern Medical Association and Constellation Quality Health. The Southern Medical Association is accredited by the ACCME to provide continuing medical education for physicians.

In-Clinic Pharmacist Pilot (ICPP)

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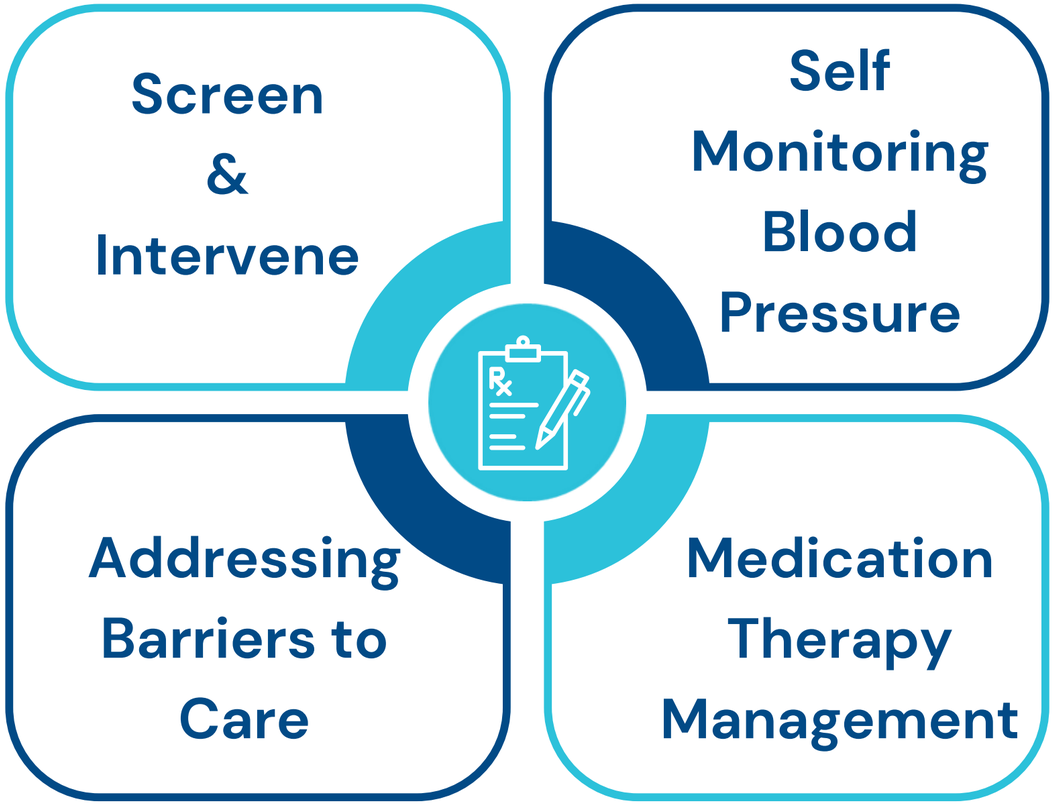
In partnership with the **South Carolina Office of Rural Health (SCORH)**, a community pharmacist is embedded in a clinical setting to work alongside the care team. The pharmacist delivers education, training, and direct support to improve hypertension control and address related cardiovascular disease barriers to care.



Constellation Community Care Hub (CCCH)

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WHAT IS A COMMUNITY CARE HUB?

A **Community Care Hub** is a trusted central organization that connects healthcare providers, community-based organizations, and local services to coordinate whole-person care.

ABOUT THE CONSTELLATION COMMUNITY CARE HUB

- Bridges community-clinical linkages
- Integrates Community Health Workers
- CVD CHW Training Program
- Improves heart health across the Southeast
- Prioritizes whole-person care
- Addresses non-medical drivers of health with closed loop referrals

Powered By Vega

Constellation Regional Learning Collaborative (CRLC)

Constellation Quality Health

A team-based learning initiative launched in July 2024 to support healthcare providers and community partners in improving hypertension and cardiovascular disease outcomes while addressing barriers to care.

- Annual Enrollment
- Self-Paced Learning
- Flexible Timelines
- Free CEUs*
- Implementation Support
- Tailored Coaching
- Innovative Peer Learning Network
- Practical Resources
- Recognition

* This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Southern Medical Association and Constellation Quality Health. The Southern Medical Association is accredited by the ACCME to provide continuing medical education for physicians.

CRLC Change Ideas

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PRIMARY CHANGE IDEAS		SECONDARY CHANGE IDEAS	
• Adopt a Hypertension Model • Create EHR Dashboards to Track BP Control • Develop EHR Alerts for Sustained HTN Control • Refer Patients to Lifestyle Management Program • Create HTN Champions with Role Descriptions and Workflows • Incorporate HTN Huddles • Incorporate Case Debriefs • Conduct Monthly Case Reviews • Develop and Tailor Patient Education Materials • Provide Staff Training on Social Determinants, Cultural competence, or Bias Reduction	• Ensure Access to Properly Sized BP cuffs • Use PRAPARE Tool for Screening Non-Medical Drivers of Health • Distribute SMBP Logs or Patient Education Flyers • Provider-Initiated Discussions During Visits • Conduct Case Debriefs After HTN-Related Events • Incorporate Inclusive Representation in the HTN Team • Share Data with Staff/Leadership Via Reports, Dashboards, or Grand Rounds • Document and Track Quality Measures (HTN, CVD, Diabetes, CKD, Cholesterol) • ***Customized Change Idea***	• *Develop SMBP Program or Support Existing SMBP Program with Device Distribution* • *Refer to SMBP Program* • *Employ Community Health Workers* • *Conduct a Practice-Wide Equity Audit and Action Plan*	• *Expand the use of Clinical and Social Data Integration in EHR* • *Conduct Closed-Loop Referrals with Community-Based Organizations* • *Implement Patient Engagement and Lifestyle Management Programs* • ***Customized Change Idea***

CRLC Quick Start Implementation Guide

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1

Orientation & Team Formation

- Attend the virtual onboarding session.
- Form a multidisciplinary team.
- Select a Primary Champion to coordinate efforts.

2

Intake & Baseline

- Complete the 13 Question Intake Form.
- Identify strengths and gaps with your coach.
- Submit baseline populations measures data.

3

Select Change Ideas

- Review the Change Package and Coaching Guide.
- Select **at least one** Primary Change Idea to implement.
- Plan and begin one PDSA cycle around your chosen change idea.

4

Coaching & Peer Learning

- Participate in coaching calls as needed.
- Engage in peer learning sessions and the online community of practice.
- Use provided templates, workflows, and training tools.

5

Implementation & Tracking

- Carry out selected change idea(s) using rapid PDSA cycles.
- Track actions, decisions, measures, and barriers.
- Collect feedback from staff, patients, and community partners.

6

Endline & Wrap Up

- Pull endline population measures collected at baseline.
- Document progress.
- Share updates with staff and leadership.
- Celebrate and recognize team achievements.

The Constellation Regional Collaborative Team

Constellation Quality Health

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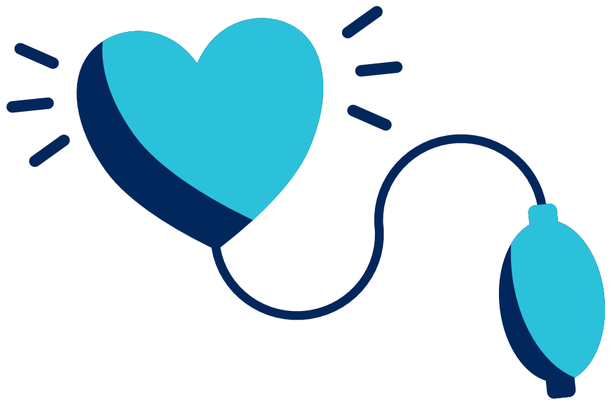

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Thank You

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