

John Clymer:

Thanks, Alison. That was a tragic, but very important update. So I appreciate it. And now we're going to open the floor for questions from participants. If you have a question, and have not already submitted it via the Zoom Q&A function, now's the time to do that. So please, please find that at the bottom of your screen. And come on. I want to begin with John Laughner. John, we've heard, like daily updates from Capitol Hill about progress, or lack thereof, toward a deal to raise the debt ceiling, and how that may affect future appropriations.

Do you have anything that, you know, what's your crystal ball telling you about where it's going to come out? And I love your suggestion, John, about putting a human face on the ramifications of severe cuts. So could you take that one degree further, and tell us what that would look like when we put that into practice?

John Laughner:

Sure. I mean, as far as a prognosis or a crystal ball, you know, right now, we're still at a standstill. President Biden has communicated that he plans to veto any legislation that would, you know, implement these large cuts, that that would, you know, there's several areas, you know, one is his student debt cancellation program. He also has, the House bill also includes provisions to require work requirements for SNAP and Medicaid. So that's a nonstarter with the White House. And then there's also, you know, the 22 percent cut. So I think we're really at a standstill.

You know, there is no historical precedent for the government not paying its debts. And so the last time they got close to this, we saw what happened in the stock market. And, for example, the NASDAQ dropped 500 points in one day, and the Dow Jones dropped 2,000 points in one day. So the last time we went through this exercise in 2011, they came within 72 hours of actually defaulting, and the United States credit standing actually was degraded by some of the folks that do our debt rankings. So I don't think anybody wants to see that happen.

So like I said, precedent, there's never been a default. So I think somehow they're going to come to an agreement. But, currently, there is no progress in this area. So we're all waiting with bated breath. Treasury Secretary Yellen came out last week, says that we could be breaching that that point on June 1st. So the clock is certainly ticking. I know the White House is inviting some of the top leaders to the White House to have some serious discussions about this. And so that's kind of where we are right now.

John Clymer: All right. Thank you, John. Turning from Capitol Hill, and the administration to CMS. The next question is for Alison. We have a participant who asked: “First, how can we make sure we get the link for submitting input to CMS, submitting comments?” And then second: “What advice do you have about making comments publicly?”

Alison: Thank you. I see a groundswell of support in the chat, which doesn’t surprise me after the great conversation that we’ve had all day today, and all the insights around the importance of SMBP and the role that it can play in hypertension control. So thank you. I’m encouraged by this, your support, and I think that we’re very hopeful that this preliminary decision can be reversed in our favor.

I will say that, John, you and your team have generously agreed to help us disseminate a very easy process for submitting public comment, where we will outline where to click, where to go, and some guidance to align, you know, our viewpoints in near term, in advance of that deadline on May 31st. So we will make that very easy process for you all. And, you know, again, thank you in advance for your support.

John Clymer: Yeah, that that’s great. Alison, thank you. And I think those comments help. I remember going back a number of years now, when we submitted a national coverage determination to obtain Medicare coverage for smoking cessation, and which wasn’t covered at the time. And on top of our submission, there were hundreds of supportive comments that poured into CMS. And that approval came through. I think it’s made a difference for tens of thousands of Medicare beneficiaries since that coverage was added. And I’m hoping that, together, we’ll be able to make a similar impact on this decision, because it clearly is the right thing to do.

Dr. Sperling, you and I’ve talked previously about one of the roadblocks or impediments to increasing the priority on hypertension control in clinical practices, being the way that the clinicians have to look at the financial picture. I mean, they can’t save the world if they can’t pay the rent, right? So I think you’ve suggested that there are some tools that can help us demonstrate to clinicians, an opportunity, financial opportunity that exists alongside the clinical opportunity. So if you could talk a little bit about that, I think that’d be really helpful.

Dr. Sperling: Yeah, thanks, John. And first of all, I really appreciate, and I know many really appreciated the updates from John and Alison. I love

the Mayor Simmons' daughters lesson, you know, kind of as a highlight of today's meeting. But getting back to the economic case. You know, it depends on which lane we're driving in US healthcare. But for many, you know, especially on the, you know, the backend of the challenges the pandemic for many hospitals and health systems, there are challenges related to staffing. And so many of these systems are treading water right now, and trying to recoup.

So, hypertension, we clearly as I mentioned, during the interview, with Marcus, the cases there, the science, the public health, the health equity. So that part, we don't need any more data. But in terms of aligning incentives, there is a tool that we developed, and it's on the Million Hearts website. We hope to, I guess, fine-tune this tool, and the key is getting it out and about. But it's a tool to implement those two CPT codes that have been in place before the onset of the pandemic. I can't rattle off the code numbers off the top of my head, but one is to help with teaching how to check a home blood pressure.

And I think one of the best, I'm a teacher, so one of the best ways to learn is to be a teacher. And so, hopefully, it'll be a bidirectional benefit for learning how a resting blood pressure should be taken. Also, talking about validated cuffs as we have today. And there's another code related to utilizing the SMBP data in a meaningful and purposeful way to improve partnered care and blood pressure control. And so these, along the lines of the reimbursement, it's about \$15 and whatever cents for each of these codes.

So on an individual patient level, you know, quite small, but then we make this economic case, to magnify that and give examples to a clinician, a practice, a hospital health system, for the number of patients they're caring for that are Medicare patients or potential private insurance where they might get reimbursed. And, importantly, besides just being a tool to get paid for what many of us are doing already, it's a tool to reinvest in the practice's team-based care, and how do we how do we focus on the team, support the team, coming back to improving hypertension control? So that we can make this economic case, and hopefully there'll be more people out there as Million Hearts hypertension control champions in the future.

John Clymer:

Terrific. Thank you. Dr. Jones, you've led as president, one of the largest medical specialty societies in the country, AAFP. Can you in 30 or 40 seconds, give us some advice about how those of us, who are advocates can bring this to the attention of clinicians and

help them recognize the economic case that Dr. Sperling just outlined?

Warren Jones:

Well, first of all, I have to apologize, I'm away from my camera right now. So please allow my voice to carry. I think the key thing that Dr. Sperling just talked about, was the need to make sure that we effectively educate and teach our patients and build relationships. I think the number one way to make that occur is to go through the specialty societies, all of them, and the state associations, and make sure that there's harmony there. That is not an us against them situation. It's what do collectively, to, to work for the best interest of our patients.

As been said earlier, the data are there to show that these kinds of things work, and they are effective, especially in underserved populations. So I really hope that we can come together, have meaningful communications. I would be more than happy to leverage any opportunities I have to get before my colleagues and talk to them about the need for them to be more involved, and to work for the advantages of their patients. And I simply ask that those of us who are clinicians, reach out to our colleagues and make sure we accomplish that. I hope that answers your question, John.

John Clymer:

Yeah, that's helpful. Dr. Jones. And it leads me to a follow-up question for Dr. Fine, from your interview or your conversation with Hilary Wall about preventing and managing hypertension before, during, and post-pregnancy. From my understanding, it seems like we have some work to do to raise the priority on hypertension in the eyes of the American College of Obstetrics and Gynecology. Do you have any, any suggestions about how we can make that case? How we can help them see the importance of managing blood pressure for their patients?

Dr. Fine:

I think the results of the CHAP trial that someone mentioned in the chat is leading that – is stimulating that kind of discussion within that organization. I'm not part of that discussion, but I think that discussion is going on. So I think people who are in that professional organization who want to join that discussion should obviously do so.

John Clymer:

Okay. Very good. Thank you.

Warren Jones:

John?

John Clymer:

Yes?

Warren Jones: As a family physician, who has delivered quite a few babies in my career, I can tell you that I don't know of a single individual that clinician is delivering today, that's not sensitive to the need to accurately and effectively manage blood pressure during their pregnant patients. It's very much is very much on the minds of those who deliver, especially in areas of the country where we have poor neonatal outcomes. And when we're dealing with populations at risk, like African American females. I can tell you that it's very much on their minds. We just got to find a way to make it a part of the lexicon and the dialogue that's going around and make sure everyone is aware.

John Clymer: Thank you. And that comment reminds me of the US is standing in the world in terms of maternal mortality, which is not just abysmal, it's embarrassing, and it must not stand. And certainly there the black white disparities that Keith Ferdinand pointed out earlier in terms of hypertension and cardiovascular health, and the same is true with maternal health and mortality. And for all of us who I think are bound together by their commitment to health equity, this has to be a priority for us.

Next question is for John Laughner. John, could you explain how the CDC cardiovascular disease funding opportunities that you outlined will be affected if the drastic cuts were to be made? The questioner said: "I think you mentioned that ten states would lose their funding for cardiovascular disease prevention." Is that right?

John Laughner: Yeah. That's correct. And, you know, through our advocacy, and you know the Division for Heart Disease and Stroke Prevention has been expanded to 50 states. And that took years to achieve. And so this would certainly be backtracking on those efforts if the CDC were forced to cut that by ten states. So, you know, most states do rely on this funding to run their public health campaigns for cardiovascular disease. So that would certainly be detrimental.

Estimates also have WISEWOMAN being cut by five states. And so that's also backtracking. You know, as I mentioned, they're hoping to get up to 40 states after years of new investment. And once again, we'll be backtracking in the wrong direction for this program. So those are the preliminary numbers for those two programs that we focus on.

John Clymer: Thanks, John. And I think we can connect that to the trend that Karol Watson pointed out early in this convening, about the end of the steady declines in cardiovascular disease mortality, and the leveling off. And in fact, in recent years, slight up ticks. We

certainly could expect that trend to worsen if we lose those resources in entire states. Karol, thank you for the great work that you're doing. Alison, we had another question. Somebody's wondering, and this is way above my paygrade, might there be an opportunity to support validated blood pressure devices, for out of office use, categorized not as durable medical equipment, but as something that would be part of the pharmacy benefit or another benefit similar to how glucometers are covered?

Alison: I appreciate the question, and the collaboration on trying to solve this coverage issue. We are currently focused on the way in which we requested the benefit determination now under the DME realm and made many parallels to the glucometer coverage that exists now for patients with diabetes. We will pursue other pathways if we're not successful in this regard. So I appreciate the thinking and we will continue to collaborate on that, and certainly invite the comments of others on this.

John Clymer: Thank you, Alison. Jen, I think from the comments I've seen, a lot of people were really energized by the commitment Mayor Simmons certainly makes evident and all the things that they're doing with Move With the Mayor and their health council in Greenville. And I know you are just at the African American Mayors Association annual meeting. What's the what's the zeitgeist? What's the buzz and sort of the energy level among mayors as a group about enacting community health, and economic prosperity, and about health equity.

Jen: It's absolutely something that they're invested in, and really having conversations, and taking action around. For example, Mayor Wright-Patterson in Mount Vernon, New York was talking about some ways that within her community, they're using funding for food banks to be able to provide lower sugar and lower sodium options to food bank recipients because of the importance of reducing diabetes and hypertension levels. And a lot of the conversations that the mayors were having were in the importance of language that's being used.

So as Mayor Simmons talked about, like instead of saying hypertension, that they're talking about blood pressure, and using the term "blood sugar", so really relating to the community and trying to lead by example. So there are a lot of great efforts going on. I know we had a few cities represented as participants on the line today, and all the cities participating in the Move With the Mayor initiative are out – you can watch our social media feeds with the hashtag *movewiththemayor*, and see all the cities who are

participating, are using communications toolkits. I know Dr. Sperling mentioned “Live to the Beat”. We’re partnering with them this year, and Move With the Mayor, so providing assets to the cities to be able to communicate, plug and play about the importance of hypertension in communities, and easy messages that people can understand and take action on. So it’s really a group effort. So thank you to everyone here for your partnership and assets. They are being implemented by the cities.

John Clymer:

Great. Well, that’s a high energy way to wrap up our Q&A session. So thank you, Jen. And thank you to all the speakers today. And to the people who asked the great questions. We’ve heard today about concrete actions that your organization can take that will help increase the use of self-measured blood pressure in the area you serve, and increase hypertension control in our nation. Larry Sperling’s comment earlier about the common thread among hypertension control champion practices, being a champion within the practice. I think that is so important.

And certainly we’ve seen other examples today of the value of champions, not only in clinical settings, but outside in the community as well, such as Mayor Simmons. So one thing we can begin to do, starting next week, is recruit and equip people who are in positions to be champions to step up and take the mantle and provide leadership in their setting to improve hypertension control and make it a priority, wherever they are.

Julie Harvill and I want to know what you think about this meeting. So please open the link that is in the chat box now, and take a couple of minutes right now to fill out the survey. We’re going to read your feedback, and we do use it to continuously improve The National Forum’s convenings. I want to thank again The National Forum’s contributing members Amgen, AstraZeneca, Johnson & Johnson, Bristol-Myers Squibb-Pfizer, Novartis, Merck, and Boehringer Ingelheim. Their support made this convening possible.

And I want to call out Julie Harvill, the director of this convening Stacy Rezendes, who assisted with so much of the planning and preparation, and the technical producer of the convening, John **Barcus**. The words “we couldn’t have done it without you”, truly apply to Julie, Stacy, and John. And finally, please mark your calendar now for The National Forum’s 21st annual meeting on October 26th. We are planning for a hybrid meeting in Washington, D.C., and online.

Hypertension control is falling in America, and strokes are rising. In just the time that we've been on this convening, 260 people in the US had strokes. But it doesn't have to stay that way. We know how to improve blood pressure control, and we heard examples today of people in places that are doing it. As you prepare to leave this virtual convening, after you fill out the evaluation, I urge you to take on at least one of the actions the speakers described today. Because, together, we can make our world better.

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