Missouri Million Hearts

What One (Awesome) State Can Achieve

Missouri Million Hearts Coalition
Sharing Prevention Innovations in CVD
February 2, 2018

Janet Wright MD FACC

Disclaimer/Disclosure

The opinions expressed by the speaker do not necessarily reflect the opinions of the US Department of Health and Human Services, the Public Health Service, the Centers for Disease Control and Prevention, or the Center for Medicare and Medicaid Services.

Dr. Wright has no conflicts to disclose.
Today’s Objectives

• Kick the tires on Million Hearts 2022
• Discover alignments, opportunities, and resources
• Add value to Missouri’s 2018-2021 actions

Heart Disease and Stroke in the U.S.

• More than 1.5 million people in the U.S. suffer from heart attacks and strokes per year
• More than **800,000 deaths per year** from cardiovascular disease (CVD)
• CVD costs the U.S. hundreds of billions of dollars per year
• Heart disease is the greatest contributor to racial disparities in life expectancy
Improvements in BP control and Cholesterol management and in trans-fat and sodium policies

Target will likely be hit for tobacco prevalence

By 2014, nearly 115,000 CV events were prevented

We estimate that up to 500K events will have been prevented when final data are available in 2019

Million Hearts = 120 partners, 20 federal agencies, all 50 states, and the District of Columbia
Heart Disease and Stroke Mortality Trends, 1950-2015

Heart Disease

All Cardiovascular Disease

THE CVD HEADWIND

Stroke death declines have STALLED in 3 out of every 4 states.

**CONTINUED** = death rates continued to decrease steadily from 2000-2015 in adults 35 years and older

**SLOWED** = the decrease in death rates slowed down over time

**REVERSED** = the death rates reversed from decreasing to increasing

Heart Disease Mortality Rates

County-level percent change in heart disease death rates, United States, Ages 35-64, 2010-2015

Over 50% of counties had increases in heart disease mortality from 2010-2015.

Source: Adam Vaughan, PhD, MPH (email communication, December 11, 2017); Vaughan et al. Widespread recent increases in county-level heart disease mortality across age groups. Annals of Epidemiology. 2017;27:796-800

Simulation Modeling for Million Hearts® Planning

Risk Factors Assessed
- Aspirin use for secondary CVD prevention
- Blood pressure control
- Cholesterol management
- Smoking prevalence
- Secondhand smoke exposure
- Mean daily sodium intake reduction
- Obesity prevalence
- Diabetes incidence
- Diabetes management
- Particulate matter
- Poor fruit and vegetable diet
- Excess junk food
- Inadequate physical activity
Relative Contributions to “the Million”

Notes: Describes the estimated number of events prevented if Million Hearts objectives are gradually achieved during 2017-2021. The events included closely align with those outlined in Ritchey et al., JAHK 2017;6(3). The total no. of expected events prevented does not equal the sum of events prevented by risk factor type as those totals are not mutually exclusive. The “aspirin when appropriate” intervention reflects aspirin use for secondary prevention only.


Million Hearts® 2022

Aim: Prevent 1 Million Heart Attacks and Strokes in 5 Years

Keeping People Healthy

Optimizing Care

COMMUNITY

Priority Populations
### Million Hearts® 2022

**Priorities and Goals**

<table>
<thead>
<tr>
<th>Keeping People Healthy</th>
<th>Optimizing Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Sodium Intake</td>
<td>Improve ABCS*</td>
</tr>
<tr>
<td>Decrease Tobacco Use</td>
<td>Increase Use of Cardiac Rehab</td>
</tr>
<tr>
<td>Increase Physical Activity</td>
<td>Engage Patients in Heart-healthy Behaviors</td>
</tr>
</tbody>
</table>

### Improving Outcomes for Priority Populations

- Blacks/African Americans with Hypertension
- 35- to 64-year-olds due to rising event rates
- People who have had a heart attack or stroke
- People with mental illness or substance use disorders

*Aspirin use when appropriate, Blood pressure control, Cholesterol management, Smoking cessation

### Keeping People Healthy

#### Goals

<table>
<thead>
<tr>
<th>Goals</th>
<th>Effective Public Health Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduce Sodium Intake</strong></td>
<td>• Enhance consumers’ options for lower sodium foods</td>
</tr>
<tr>
<td>Target: 20%</td>
<td>• Institute healthy food procurement and nutrition policies</td>
</tr>
<tr>
<td><strong>Decrease Tobacco Use</strong></td>
<td>• Enact smoke-free space policies that include e-cigarettes</td>
</tr>
<tr>
<td>Target: 20%</td>
<td>• Use pricing approaches</td>
</tr>
<tr>
<td><strong>Increase Physical Activity</strong></td>
<td>• Conduct mass media campaigns</td>
</tr>
<tr>
<td>Target: 20% <em>(Reduction of inactivity)</em></td>
<td>• Create or enhance access to places for physical activity</td>
</tr>
<tr>
<td></td>
<td>• Design communities and streets that support physical activity</td>
</tr>
<tr>
<td></td>
<td>• Develop and promote peer support programs</td>
</tr>
</tbody>
</table>
## Optimizing Care

<table>
<thead>
<tr>
<th>Goals</th>
<th>Effective Health Care Strategies</th>
</tr>
</thead>
</table>
| **Improve ABCS**<br>Targets: 80% | • Teams—including pharmacists, nurses, community health workers, and cardiac rehab professionals  
• Technology—decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care  
• Processes—treatment protocols; daily huddles; ABCS scorecards; proactive outreach; finding those with undiagnosed high BP or cholesterol, tobacco use, PM2.5 exposure  
• Patient and Family Supports—training in home blood pressure monitoring; problem-solving in medication adherence; counseling on nutrition, physical activity, tobacco use, risks of particulate matter; referral to community-based physical activity programs and cardiac rehab |
| **Increase Use of Cardiac Rehab**<br>Target: 70% |
| **Engage Patients in Heart-healthy Behaviors**<br>Targets: TBD |

*Aspirin use when appropriate, BP control, Cholesterol management, Smoking cessation

---

### Improving Outcomes for Priority Populations

<table>
<thead>
<tr>
<th>Priority Population</th>
<th>Objectives</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| Blacks/African Americans | • Improving hypertension control | • Implement tailored protocols  
• Problem-solve in med adherence |
| 35-64 year olds | • Improving HTN control and statin use  
• Decreasing physical inactivity | • Implement tailored protocols  
• Increase access to and participation in community-based activity programs |
| People who have had a heart attack or stroke | • Increasing cardiac rehab referral and participation  
• Avoiding exposure to particulate matter | • Use opt-out referral and CR liaison visits at discharge; ensure timely enrollment post-discharge  
• Increase use of Air Quality Index tools |
| People with mental illness or substance abuse disorders | • Reducing tobacco use | • Integrate tobacco cessation into behavioral health treatment  
• Institute tobacco-free policy at mental health and substance use treatment facilities  
• Tailored quitline protocols |
Discussion #1
Questions? Reactions? Ideas?

• Are any MH “priority populations” a match?
• Are your clinical settings already well-linked to community resources, especially for sources and sites of safe, affordable, accessible PA?
• What qualifies as “patient engagement in heart-healthy behavior”?
• What the heck is PM2.5 and why should we care?

Missouri ABCS Prevalence

<table>
<thead>
<tr>
<th>Measure</th>
<th>Missouri</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin for secondary prevention of heart attack and stroke</td>
<td>44.3%</td>
<td>76.2%</td>
</tr>
<tr>
<td>Blood Pressure (18+)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hypertension (self-reported)</td>
<td>34.1%</td>
<td>30.9%</td>
</tr>
<tr>
<td>• Hypertension medication use</td>
<td>77.3%</td>
<td>78.5%</td>
</tr>
<tr>
<td>Cholesterol (20+)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• High Total Cholesterol</td>
<td>37.1%</td>
<td>36.3%</td>
</tr>
<tr>
<td>Smoking (18+)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Current Smoking</td>
<td>22.1%</td>
<td>17.1%</td>
</tr>
</tbody>
</table>

Source: BRFSS, 2013 (aspirin); 2015 (blood pressure, cholesterol); BRFSS 2016 (smoking)
Missouri Community Health Centers

<table>
<thead>
<tr>
<th>Measure</th>
<th>Average (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin When Appropriate</td>
<td>76% (54%-97%)</td>
</tr>
<tr>
<td>Blood Pressure Control</td>
<td>58% (42%-84%)</td>
</tr>
<tr>
<td>Cholesterol Management</td>
<td>79% (61%-92%)</td>
</tr>
<tr>
<td>Smoking Assessment and Treatment</td>
<td>85% (72%-100%)</td>
</tr>
</tbody>
</table>

Source: HRSA UDS Data, 2016

Avoidable Deaths in Missouri

- Nationally, the total avoidable heart disease and stroke death rate is **58.2** per 100,000
- In Missouri, the rate is **70.1** per 100,000

Source: CDC Interactive Atlas of Heart Disease and Stroke, 2013-2015
Heart Attack Hospitalization Rate and Cardiac Rehabilitation Programs in Missouri

Source: CDC Interactive Atlas of Heart Disease and Stroke, 2012-2014 and 2015

New for 2022

- Physical activity
- Cardiac Rehab
- Engaging Patients in Heart-healthy Behaviors
- “Priority Populations”
- Particle pollution
Why Do We Care about Activity?

**Physical Activity Benefits All Americans**
- Benefits for Children
  - Improves aerobic fitness
  - Improves muscular fitness
  - Improves bone health
  - Promotes favorable body composition
  - Improves attention and some measures of academic performance (with school physical activity programs)
- Benefits for Adults
  - Lowers risk of high blood pressure
  - Lowers risk of stroke
  - Improves aerobic fitness
  - Improves mental health
  - Improves cognitive function
  - Reduces arthritis symptoms
  - Prevents weight gain
- Benefits for Healthy Aging
  - Reduces risk of falling
  - Improves balance
  - Improves joint mobility
  - Extends years of active life
  - Helps prevent weak bones and muscle loss
  - Delays onset of cognitive decline

**Physical Activity Benefits Communities**
- Economic
  - Building active and walkable communities can help
- Mobility
  - Increase levels of retail economic activity and employment
  - Increase property values
  - Support neighborhood revitalization
  - Reduce health care costs

**Safety**
- Walkable communities can improve safety for people who walk or roll in wheelchairs, ride bicycles, and drive.

**Workforce**
- Physically active people tend to take fewer sick days.

---

Why Else Do We Care about Activity?

**Why Our Work is Important**
- Too few Americans get the recommended amount of physical activity.
- Only 1 in 5 adults and 1 in 5 high school students fully meet physical activity guidelines for aerobic and muscle-strengthening activities.

**Physical Inactivity Costs Lives & Dollars**
- Inactivity contributes to 1 in 10 premature deaths.
- $117 billion in annual health care costs.

**Many Americans Do Not Have Safe or Convenient Places to Be Active**
- Only 39% of the US population lives within half a mile of a park.
- Only 40% of school-aged youth who live a mile or less from school report that they usually walk to school.

---

04/11/2018
Key Recommendations – 2008 Aerobic Physical Activity Guidelines

• Regular physical activity reduces the risk of many adverse health outcomes.
  • **Adults should avoid inactivity**
• At least 150 minutes each week of moderate-intensity physical activity, such as brisk walking
• Alternatives are 75 minutes a week of vigorous aerobic activity or a combination of the two
• Add in 2 or more days a week of muscle-strengthening activities

Recommendation: Community Preventive Services Task Force Built Environment

Combine one or more interventions from each category

<table>
<thead>
<tr>
<th>Pedestrian and Bicycle Transportation System Intervention Component</th>
<th>Land Use and Environmental Design Intervention Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Street pattern design and connectivity</td>
<td>• Mixed land use</td>
</tr>
<tr>
<td>• Pedestrian infrastructure</td>
<td>• Increasing residential density</td>
</tr>
<tr>
<td>• Bicycle infrastructure</td>
<td>• Proximity to community or neighborhood destinations</td>
</tr>
<tr>
<td>• Public transit infrastructure and access</td>
<td>• Parks and recreational facility access</td>
</tr>
</tbody>
</table>

https://www.thecommunityguide.org/findings/physical-activity-built-environment-approaches
Tips to Improve Physical Activity

- Commit to 10 minutes a day for six to eight weeks
- Then add a second 10-minute bout a day or extend to 15 to 20 minute daily
- Each night, schedule activity into tomorrow’s routine
- Recruit a buddy or a group
- Track your daily & weekly activity by using a log
- If safe, bike or walk from home to work and back

Tips for Clinicians to Improve Physical Activity

- Use motivational interviewing or other counseling techniques
- Recommend a 10 minute bout of daily physical activity 1 to 3 times per day, to those who are currently inactive
- Encourage patients to develop a “buddy” system
- Encourage patients to keep a physical activity diary/log
  - [http://www.cdc.gov/healthyweight/pdf/Physical_Activity_Diary_CDC.pdf](http://www.cdc.gov/healthyweight/pdf/Physical_Activity_Diary_CDC.pdf)
- Refer patients to a hospital wellness program or other community resource
Tips for Communities to Improve Physical Activity

• Create or enhance access to places for physical activity
• Design communities and streets that support physical activity
• Develop and promote peer support groups

Million Clicks for Million Hearts®

• Allentown, PA Health Bureau program
• 10 click-in stations on walking paths around the city
• Participants tap a keytab to track their walks
• PRIZES!
Cardiac Rehab: Saving Lives, Improving Health

**Bottom Line**

- It works
- It’s “covered”
- It is under-utilized especially in women, people of color, those with lower socio-economic status, and by geography.

Cardiac Rehab: Saving Lives, Improving Health

**What is it?**

Comprehensive, team-delivered programs designed to

- Limit the effects of cardiac illness
- Reduce the risk for sudden death or re-infarction
- Control cardiac symptoms
- Stabilize or reverse the atherosclerotic process
- Enhance the psychosocial and vocational status of patients

Typically administered in 36 sessions over ~12 wks
Cardiac Rehab: Who Benefits?

Strong evidence of benefit--and good insurance coverage

• Those with a prior heart attack or stable angina
• Systolic heart failure and EF < 35%
• Stent or angioplasty
• Peripheral arterial disease with claudication
• Bypass, valve, or heart or lung transplant surgery

Cardiac Rehab: What is the Evidence?

• Reduces
  • Death from all causes by 11-24%
  • Death from cardiac causes by 26-31%
  • Hospitalizations by 31%
• Improves
  • Adherence to medications by 31%
  • Functional status, mood, and Quality of Life scores
• More is Better
  • 36 vs fewer sessions reduces risk of heart attack and death
  • 25 sessions is generally considered a healthy “dose”
System-level Barriers to CR Referral

Referrals are generally ≤30% of eligible patients

• Referral barriers include
  • Lack of awareness of the benefits
  • No clear, consistent signal to patients and families
  • CR program is not integrated into CV services
  • No automated electronic referral process
    • “Opt-in” hospital discharge orders

Patient-Level Barriers to Participation

• Logistics
  • Transportation/parking
  • Convenient hours
  • Proximity of programs
• Cost-sharing
• Competing responsibilities
• Cultural and language issues
Use among Medicare Fee-for-service Beneficiaries

- ~450,000 beneficiaries were eligible in 2013 (does not include those with heart failure)
- 20% used CR at least once in 12 months
- 57% of CR users completed 25 or more sessions

Number of CR Sessions per User

<table>
<thead>
<tr>
<th>Number of Sessions</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-11 sessions</td>
<td>19%</td>
</tr>
<tr>
<td>12-24 sessions</td>
<td>23%</td>
</tr>
<tr>
<td>&gt;25 sessions</td>
<td>57%</td>
</tr>
<tr>
<td>&gt;36 sessions</td>
<td>5%</td>
</tr>
<tr>
<td>25-36 sessions</td>
<td>52%</td>
</tr>
</tbody>
</table>

Cardiac Rehab Utilization Rates among Eligible Medicare Fee-for-service Beneficiaries by Age, Gender, Race/Ethnicity, 2013

- Eligible for CR and initiated
- Initiated CR and completed*

*Completed 25 or more CR sessions

Source: Centers for Medicare and Medicaid Services' Chronic Conditions Data Warehouse
Cardiac Rehab Utilization Rates among Eligible Medicare Fee-for-service Beneficiaries by Age, Gender, Race/Ethnicity, 2013

*Completed 25 or more CR sessions
Source: Centers for Medicare and Medicaid Services’ Chronic Conditions Data Warehouse

Cardiac Rehab Utilization Rates among Eligible Medicare Fee-for-service Beneficiaries by Age, Gender, Race/Ethnicity, 2013

*Completed 25 or more CR sessions
Source: Centers for Medicare and Medicaid Services’ Chronic Conditions Data Warehouse
CR Referral after Cardiac Stent

- 60% referral rate
- The hospital was the most important factor for predicting referral rate
- Rates ranged from 0 to 100%

Aragam et al, J Am Coll Cardiol 2015 May 19; 65 (19): 2079

...increasing CR participation from 20% to 70% would save 25,000 lives and prevent 180,000 hospitalizations annually in the U.S.
Million Hearts CR Collaborative
2018 Action Plan Objectives

• *Increase awareness of the value* among systems, clinicians, patients and families, employers, payers
• *Increase use of best practices* for referral, enrollment, and participation; address knowledge gaps.
• *Reduce disparities* in CR referral, participation, and program staffing
• *Increase sustainability* of CR programs through innovations in program design, delivery, and payment
• *Measure, monitor, report progress* to the 70% aim

Engaging Patients in Heart-healthy Behaviors

• Self-measured BP Monitoring
• Participation in the Diabetes Prevention Program or Chronic Disease Self-Management Program
• Participation in Cardiac Rehab
• In consideration
  • Shared Decision-making around statin use
  • Keeping a Physical Activity log and sharing with clinical team
Self-Measured BP Monitoring

• Strong evidence for SMBP + clinical support for achieving control
  • 1:1 counseling
  • Group classes
  • Web-based or telephonic support
• Good evidence for SMBP for confirming diagnosis

The BP Power Cycle

Self-measured blood pressure readings
Lifestyle habits (e.g., smoking, diet, exercise)
Medication side effects and adherence barriers
Insights into variables affecting control of blood pressure

Adjustments to medication type and dose to achieve goal blood pressure
Suggestions to achieve lifestyle changes
Actions to sustain or improve adherence
Advice about community resources to assist in controlling blood pressure

Clinician

Patient

2017 Guidelines SMBP Recommendations

<table>
<thead>
<tr>
<th>Recommendation for Out-of-Office and Self-Monitoring of BP</th>
</tr>
</thead>
<tbody>
<tr>
<td>References that support the recommendation are summarized in Online Data Supplement 3 and Systematic Review Report.</td>
</tr>
<tr>
<td><strong>COR</strong></td>
</tr>
<tr>
<td>I</td>
</tr>
</tbody>
</table>

SR indicates systematic review.

<table>
<thead>
<tr>
<th>Recommendation for Monitoring Strategies to Improve Control of BP in Patients on Drug Therapy for High BP</th>
</tr>
</thead>
<tbody>
<tr>
<td>References that support the recommendation are summarized in Online Data Supplement 29.</td>
</tr>
<tr>
<td><strong>COR</strong></td>
</tr>
<tr>
<td>I</td>
</tr>
</tbody>
</table>
SMBP Implementation Challenges

- Lack of a standard definition, protocol
- Clinicians often don’t trust readings from outside
- Health IT limitations
- Patient-generated data are not used in quality metrics
- Coverage for monitors
- Reimbursement for clinician time to
  - Train patients and families
  - Validate monitors
  - Interpret home readings and provide timely advice

Components of an Ideal System

- Person/Patient
- Validated BP monitor
- Transmitter of all
- Training and education
- Habit
- Value proposition
  
  Clinician/Team
  Confidence in measurements
  Receiver & transformer
  Training and education
  Protocol
  Business case
Characteristics of an Ideal System

• Generates a pattern of readings that is actionable
• Supports timely and well-timed interactions
• Convenient, efficient, affordable for both parties
• Adaptable and scalable across diverse settings
• Meets high standards of satisfaction for both parties
• Leads to rapid, safe, and sustained BP control

Path to the Ideal System

- Compelling case for accuracy and OOO readings
- Billing codes and/or value-based contracting
- Performance measure(s) that consider OOO readings
- EZ, smart connection between patients and clinicians
- Exemplars and implementation guidance
- Activation of people with HTN to “own” their BPs
Progress to the Ideal System?

✓ Compelling case for accuracy and OOO readings
  - Billing codes or value-based contracting
  - Performance measure(s) that consider OOO readings
  - EZ, smart connection between patients and clinicians
  - Exemplars and implementation guidance
  - Activation of people with HTN to "own" their BPs

National SMBP Strategy

• Long-term vision: SMBP will be accessible to everyone for diagnosis and management of hypertension
• National experts—researchers, clinicians, public health experts, community organizations—have convened to advance this practice
Guidance for clinicians on:
• Training patients to use monitors
• Checking home machines for accuracy
• Suggested protocol for home monitoring
• Cuff loaner program

[https://millionhearts.hhs.gov/tools-protocols/smbp.html](https://millionhearts.hhs.gov/tools-protocols/smbp.html)

Genesis of the Lifestyle Medicine Program

A Blue Ribbon Panel of 8 professional medical societies convened in 2010

ACPM  AMA
ACLM  ACP
AAFP  AOA
ACSM  AAP

Findings: a key impediment to improved care is a gap in physicians’ education and training about lifestyle factors that lead to many of the leading chronic diseases. "Physician Competencies for Prescribing Lifestyle Medicine" (JAMA.2010;304(2):202-203)
The Lifestyle Medicine Competencies
Curriculum Content

1. 15 Core Competencies
2. Nutrition
3. Physical Activity
4. Sleep Health
5. Emotional Wellness/ Stress Reduction
6. Tobacco Cessation
7. Alcohol Use Risk Reduction
8. Coaching Behavior Change
9. Basic and Advanced Weight Loss & LM Article Reviews

Electives

• Medical Nutrition Therapy
• Culinary Medicine

• CVD and Stroke Prevention in Underserved Populations

Tried and True for 2022

• Recognizing stellar performance
• Finding those at risk, including the undiagnosed
• Ensuring optimal treatment based on risk
• Reducing per capita sodium intake
• Decreasing tobacco prevalence
Million Hearts
Hypertension Control Champions

- 59 Champions
- Achieved control rates at or above 70%
- Collectively serve more than 15 million adults
- Range from small and solo practices to large systems
- 2018 Program announced soon

Broadway Internal Medicine, NYC
Precise BP Measurement:

**Rounding**

- Last recorded systolic BP – 163,000 patients, age 18–85, with hypertension, across three medical groups:

**Odds are Out**

Bars are colored by the last digit of systolic BP.

Blue represents a last digit of zero, which would include patients with an SBP of 100, 110, 120, 130, 140, etc.

Lighter colors correspond to even numbers, darker colors to odd numbers.
Precise BP Measurement: Before and After... What?

Distributions of BP measurements at one site—a neurology clinic

BP Measurement: Variability

- Blood pressure can vary by 5-40 points depending on technique and conditions

See: Million Hearts Self-Measured Blood Pressure Monitoring action Steps for Clinicians
www.measureup pressuredown.com/HCPref/Find/Toolkit/Plank1Tool11.pdf
Technique is Critical….and Rare

- Proper patient positioning is important for BP accuracy both at home and in the office
- Devote eternal vigilance to good technique

Who is Hiding in Plain Sight?

1. **Finding Patients with Undiagnosed Hypertension**
   - Search EHR data for patients that meet clinical criteria

2. **Establish clinical criteria for potential undiagnosed HTN**

3. **Compare to local, state, or national prevalence data**

4. **Implement a plan for addressing the identified population**

‘Undiagnosed’ Resources

- Maine Center for Disease Control and Prevention HIPS video – https://vimeo.com/136615637
- National Association of Community Health Centers – Consolidated Change Package - leverages HIT, QI, and care teams to identify hypertensive patients hiding in plain sight
- Hypertension Prevalence Estimator – For practices/systems to use to estimate their expected hypertension prevalence
- Whiteboard animation – a creative depiction of the “hiding in plain sight” phenomenon and what clinical teams can do

Standardized Treatment Protocols

- http://millionhearts.hhs.gov/resources/protocols.html
  - Hypertension control
  - Cholesterol management
  - Tobacco assessment and treatment
- Key components and implementation tips
- Road-tested and evergreen exemplars
- Customizable template for DIY
- Reduces non-clinical variation
SO.....
What Can Missourians Do?

- Individual and Family Member
- Healthcare Professional
- Community Member and Public Health Expert
- Health System Leader

You and Your Family

- Aim for at least 150 min/week of physical activity
- Read the labels for sodium and choose wisely
- Know and manage your ABCS
- Check the AQI and mitigate your exposure to PM 2.5
- Attend CR and encourage family and friends to do so
Healthcare Professional

• Prioritize and excel in the ABCS and CR referral

• **Teams**—including pharmacists, nurses, community health workers, and cardiac rehab professionals
• **Technology**—decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care
• **Processes**—treatment protocols; daily huddles; ABCS scorecards; proactive outreach; finding patients with undiagnosed high BP, high cholesterol, or tobacco use
• **Patient and Family Supports**—training in home BP monitoring; problem-solving in medication adherence; counseling on nutrition, physical activity, tobacco use, risks of particulate matter; referral to community-based physical activity programs and cardiac rehab

---

**Million Hearts® 2022 Clinical Quality Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Number</th>
<th>Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin When Appropriate</td>
<td>NQF 0068</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic Percentage of patients aged 18 years and older with IVD with documented use of aspirin or other antithrombotic</td>
</tr>
<tr>
<td>Blood Pressure Control</td>
<td>NQF 0018</td>
<td>Hypertension: Controlling High Blood Pressure % of patients aged 18 - 85 years with a diagnosis of HTN and an office BP of &lt;140/90 during the measurement year</td>
</tr>
</tbody>
</table>
| Cholesterol Management            | PQRS 438       | Statin Therapy for the Prevention and Treatment of Cardiovascular Disease % who were prescribed or on statin therapy during the measurement period:  
  • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease; OR  
  • Adults aged ≥21 years with a fasting or direct LDL-C level ≥ 190 mg/dL; OR  
  • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL |
| Smoking Cessation                 | NQF 0028       | Preventive Care and Screening: Tobacco Use % of patients ≥18 years who were screened about tobacco use one or more times within 24 months and who received cessation counseling intervention if a tobacco user                                         |
| Cardiac Rehab Referral            | NQF 0643       | Referral to CR from Inpatient or Outpatient Setting % of patients with an eligible diagnosis who are referred from a hospital (or office) to an early outpatient CR program                                              |
|                                   | NQF 0642       |                                                                                                                                                                                                                  |
| BMI                               | NQF 0421       | Screening and Follow-Up % of patients ≥ 18 years with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter. |
### A Small Set of High Impact Measures, Widely Embedded

**Focuses Action, Reduces Burden, Strengthens Performance Assessment**

#### Million Hearts® Quality Measure Alignment in National Quality Reporting Systems

<table>
<thead>
<tr>
<th>Quality Reporting Initiative</th>
<th>Primary Measures</th>
<th>Secondary Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aspirin when Appropriate</td>
<td>Blood Pressure Control</td>
</tr>
<tr>
<td>CMS Quality Payment Program</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>AHRQ EvidenceNow</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>ABFM Prime Registry</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>AHA Guideline Advantage</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>ACP Genesis Registry</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>ACC PINNACLE Registry</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>CMS ACO Shared Savings</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>TCPI</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>CMS Home Health CV Data Registry</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>HRSA Uniform Data System</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Comprehensive Primary Care</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>IHS RPMS</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>Medicaid Adult Core Set</td>
<td>No</td>
<td>✓</td>
</tr>
</tbody>
</table>

✓ Indicates measure alignment as of February 2017
† Measure is not identical, but similar and meets stakeholders needs
‡ Measure will be added for reporting in 2019 after e-specifications are released in May 2017

NOTE: ABCS measures are in the Cardiology, Internal Medicine, and General Practice/Family Medicine Specialty Measure Sets

---

### Community Members and Public Health Experts

- Advocate for smoke-free space policies and pricing strategies, inclusive of e-cigarettes
- Serve or request healthy food at all meetings and in all facilities
- Contribute to healthy design of your community and to accessible, affordable, and safe places to be active
- Improve awareness of the local air quality index
- Build linkages between health systems and community resources
Health System Leader

Set Expectations and Equip Your Teams to

• Achieve 80% performance on the ABCS among ambulatory primary care and relevant (cardiology, nephrology, endocrinology) specialty practices
• Achieve 90% referral to CR programs, convenient for the patient
• Achieve 70% participation rate among those eligible for CR
• Achieve 80% referral to tobacco cessation services at discharge
• Adopt procurement and food labeling practices consistent with national guidelines

Health System Leader

• Adopt policies and practices to ensure clean air for patients, visitors, and staff
  • smoke free policies that include e-cigs
  • no-idling policies for deliveries
  • education about impact of poor air quality
  • posting of local Air Quality Index on site
• Use benefit design to enhance employee health: no cost-share for hypertension, statin, and tobacco cessation medications and BP monitors; on-site BP monitoring
• Sponsor walking and other physical activity programs
• Recognize/reward high performance on ABCS and CR measures
Select an action that fits; set an aim, gather a team, measure your way to better

Check out resources at millionhearts.gov
  - Hypertension Control Change Package
  - SMBP and Hiding in Plain Sight tools
  - Cardiac Rehab Change Package, Fall 2018

“Adopt” the Million Hearts microsite for Clinicians

Join the CDC Grand Rounds, Feb 20th

Join the CR Collaborative if you are ready to act!

---

Million Hearts® Microsite for Clinicians

- Features Million Hearts® protocols, action guides, and other QI tools
- Syndicates LIVE Million Hearts® on your website for your clinical audience
- Requires a small amount of HTML code—customizable by color and responsive to layouts and screen sizes
- Content is free, cleared, and continuously maintained by CDC

Available at https://tools.cdc.gov/medialibrary/index.aspx#microsite/id/279017
New Resources

• Million Hearts® 2022 web content
  • Particle Pollution
  • Physical Activity
  • Tobacco Use
  • Partner Opportunities
  • Cardiac Rehabilitation

• EPA’s citizen science mobile app:
  Smoke Sense

Thank you

• More information about Million Hearts 2022 at www.millionhearts.gov
• Reach me at janet.wright@cms.hhs.gov
Resources and Additional Slides

Million Hearts Clinical Resources and Tools

- Action Guides
  - Hypertension Control: Change Package for Clinicians
  - Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians
  - Identifying and Treating Patients Who Use Tobacco: Action Steps for Clinicians
- Team Protocols for treating Hypertension, Tobacco use, Cholesterol
- Undiagnosed Hypertension
  - Finding Patients “Hiding in Plain Sight” change package
  - Prevalence Estimator Tool
- Making the Most of Health IT
  - Million Hearts® EHR Optimization Guides-how to find and use data on the ABCS
- Clinical Quality Measures
  - Million Hearts® ABCS
  - Million Hearts® Dashboard – quality reporting on the ABCS measures by state
- Other Tools
  - ASCVD Risk Estimator
  - Hypertension Control Champion Success Stories

Million Hearts Community Resources and Tools

• Action Guides
  • Self-Measured Blood Pressure Monitoring: Action Steps for Public Health
  • Medication Adherence: Action Steps for Public Health Practitioners
  • Medication Adherence: Action Steps for Health Benefit Managers
  • Cardiovascular Health: Action Steps for Employers
• CDC State Heart Disease and Stroke Prevention Programs
  • State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health (1305)
  • Coverdell National Acute Stroke Program
  • WISEWOMAN
  • Sodium Reduction in Communities
  • Building GIS Capacity for Chronic Disease Surveillance
• Million Hearts Cardiac Rehab Collaborative
• Healthy Is Strong
• 100 Congregations for Million Hearts

Million Hearts Consumer Resources and Tools

• Heart Age Predictor
• My Life Check ®
• High Blood Pressure: How to Make Control Your Goal
• Visit Checklist
• Supporting Your Loved One with High Blood Pressure
• Blood Pressure Wallet Card
• Smoke Free (SF)
• Million Hearts Videos (on YouTube)
• Million Hearts E-Cards & Shareables
• Mind Your Risks
• Tips from Former Smokers
Cardiac Rehab
First Actions for Hospitals

1. Establish CR as a hospital priority
   a. Inform ALL staff of the value of CR
   b. Advertise the service to eligible patients and their families
   c. Track, report, and reward referral and participation rates

2. Institute “opt-out” referral of eligible patients
   a. Identify qualifying billing codes
   b. Work with IT team to embed referral system in EHR

3. Engage hospital staff
   a. Identify and train staff liaisons
   b. Analyze current CR program data and begin to tackle issues
   c. Establish protocol for engaging other important team members

Cardiac Rehab
Actons
for Hospitals

4. Facilitate scheduling 1st session at time of referral
   a. Identify CR program most convenient for the patient
   b. Establish referral process with local CR programs
   c. Create and implement a protocol for scheduling the 1st session

5. Reach out and reward eligible and enrolled patients
   a. Provide appointment cards
   b. Send motivational letters from hospital or program leadership
   c. Send text message reminders
   d. Celebrate milestones to encourage completion of ≥ 25 sessions
Cardiac Rehab
Actions for Hospitals

6. Minimize obstacles for eligible patients
   a. Establish convenient hours
   b. Offer free parking or public transit vouchers
   c. Diversify workforce
   d. Make the program gender-specific where possible
   e. Provide transparent insurance/cost-sharing information

7. Establish CR referral performance measure
   a. Create a unique measure in EHR system

8. Identify and nurture community stakeholders that can support CR referral and participation

American Medical Association Resolution

“...urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle medicine interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine.”

Adopted by American Medical Association House of Delegates, Chicago, June, 2012
[AMA Policy H-425.972]
Lifestyle Medicine - Defined

**Definition**

Lifestyle Medicine is the evidence-based therapeutic approach to prevent, treat and reverse lifestyle-related chronic diseases.

It uses comprehensive lifestyle interventions to address underlying disease risks, thereby decreasing illness burden and improving clinical outcomes within value-based medicine.

**Lifestyle Factors**

Nutrition
Physical Activity
Stress Management
Sleep
Social Support
Environmental Exposures
The Invisible Backpack

The Lifestyle Medicine Competencies Curriculum

- New comprehensive, evidence-based curriculum designed for physicians with an interest in learning the basic principles of lifestyle medicine
- Focus on how to incorporate lifestyle medicine into current clinical/population health practice
- Establishes a new standard for primary care focused on disease prevention, health promotion, and care coordination, supports new MACRA and MIPS focus
- First U.S. based continuing medical education (37 hours) curriculum that comprehensively addresses the knowledge and skill gaps doctors themselves cited as major barriers to counseling patients about lifestyle interventions
- Launched June of 2016
The Need for Continuing Medical Education

Fills the Gap In Physician training
- Lack of competency in prescribing
- Medical School and Residency Programs generally do not address Lifestyle Medicine in their programs

Patient Centered
Engages patients to take responsibility for their care via an effective physician-patient collaboration

U.S. Government Sector Program Adoption

- This Lifestyle Medicine Core Competencies program underpins training for CDC programs:
  - WISEWOMAN cardiac and vascular education

- Centers for Medicare & Medicaid Innovation/ CMS Million Hearts Innovation Awardees:
  - Provided as a grantee benefit

- Accepted for promotion via NIH’s Foundation for Advanced Education in the Sciences 2017 course catalogue
LM and the Million Hearts Priority Populations

Reducing CVD Risk Using LM

4 Continuing Medical Education Modules:

• **Module 1:** Review of the latest studies on how lifestyle change can improve hypertension and CVD outcomes.

• **Module 2:** Practical tips for implementing the lessons learned from these studies. Special considerations with regard to diet, physical activity, stress management, and sleep (e.g. salt and hypertension) for these conditions.

• **Module 3:** Managing patients with cardiovascular disease on the spectrum of socioeconomic status, ethnicity/culture, readiness to change, and severity/complexity of common comorbid conditions (such as depression).

• **Module 4:** Case studies of patients who represent typical target populations

*Funded by CDC Division of Heart Disease and Stroke Prevention*

---

**Funding Innovation in the Clinical Care Setting**

**In the Field**

ACPM will award 2 grants to clinical care organizations to implement / strengthen strategies to increase hypertension awareness, screening, and referral to evidence based programs.

Grantees will develop tools and resources including, case studies, physician education materials and provider work flows. Findings presented at ACPM annual conference.

*Funded by CDC Division of Heart Disease and Stroke Prevention*
Exercise
**Frequency:** four times each week
**Intensity:** heart rate between 100 and 140
**Time:** at least 30 minutes each session
**Type:** walking

Nutrition
**Type:** cruciferous vegetables such as broccoli, kale and Brussel sprouts
**Amount:** 1 serving (1/2 cup cooked, 1 cup fresh)
**Frequency:** once daily

For More Information
Visit: [www.ACPM.org/lifestyle-medicine](http://www.ACPM.org/lifestyle-medicine)

Stay Connected:
dpere@acpm.org