Advancing Million Hearts®:
AHA and State Heart Disease and Stroke Prevention Partners Working Together in Rhode Island

August 9, 2016
10:00 AM to 3:00 PM ET

Healthcentric Advisors
235 Promenade St., Suite 500
Providence, RI 02908
Welcome & Overview of the Day

Brenda Jenkins, RN, D.Ay., CDOE, CPEHR, PCMH CCE

Senior Program Administrator / HIT Consultant

Healthcentric Advisors
Introductions

What excites you about your role in heart disease and stroke prevention?
RECOGNITION OF MILLION HEARTS®
HYPERTENSION CHAMPION:
THUNDERMIST HEALTH CENTER

David Bourassa, MD
Chief Medical Director at Thundermist Health Center
PATIENT STORIES

Shantha Diaz
Chief Operating Officer, Neighborhood Health Plan of Rhode Island
The Million Hearts® Initiative

Advancing Million Hearts in Rhode Island

August 9, 2016

Providence, Rhode Island
Million Hearts®

Goal: Prevent 1 million heart attacks and strokes by 2017

- National initiative co-led by CDC and CMS in partnership with federal, state, and private sectors
- To address the causes of 1.5M events and 800K deaths a year, $316.6 B in annual health care costs and lost productivity and major disparities in outcomes
Key Components of Million Hearts®

Keeping Us Healthy
Changing the environment

Excelling in the ABCS
Optimizing care

Focus on the ABCS
Health tools and technology
Innovations in care delivery

## Getting to a Million by 2017: Public Health Targets

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Pre-Initiative Estimate 2009-10</th>
<th>2017 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking prevalence*</td>
<td>26%</td>
<td>24%</td>
</tr>
<tr>
<td>Sodium reduction</td>
<td>3580 mg/day</td>
<td>2900 mg/day</td>
</tr>
<tr>
<td>Trans fat reduction</td>
<td>0.6% of calories</td>
<td>0% of calories</td>
</tr>
</tbody>
</table>

* Includes all forms of combustible tobacco – cigarettes, pipes, and cigars

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National Survey on Drug Use and Health, National Health and Nutrition Examination Survey
## Getting to a Million by 2017: Targets for the ABCS

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Pre-Initiative Estimate 2009-2010</th>
<th>2017 Population-wide Goal</th>
<th>2017 Clinical Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> Aspirin when appropriate</td>
<td>54%</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>B</strong> Blood pressure control</td>
<td>52%</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>C</strong> Cholesterol management</td>
<td>33%</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>S</strong> Smoking cessation</td>
<td>22%</td>
<td>65%</td>
<td>70%</td>
</tr>
</tbody>
</table>

National Ambulatory Medical Care Survey, National Health and Nutrition Examination Survey
Million Hearts® Accomplishments*

Changing the Environment

Reduce Smoking
- Almost 4 million fewer cigarette smokers†

Reduce Sodium Intake
- More than 2 billion meals/year will have reduced sodium‡
  Draft Voluntary Guidance to Industry Released June 1, 2016

Eliminate Trans Fat Intake
- Accomplished: FDA issued the final determination on artificial trans fat§

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* Note this is a select set of notable Million Hearts® accomplishments.
† National Health Interview Survey, comparing 2011 data to 2014 data
‡ Aramark pledge http://blog.heart.org/aha-aramark-join-on-meals-initiative/
§ http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm372915.htm#top
Million Hearts® Accomplishments

Optimizing Care in the Clinical Setting

Focus on the ABCS

Millions of Americans are covered by health care systems that are recognizing or rewarding performance in the ABCS**

Health Tools and Technology

Over half a million patients have been identified as potentially having hypertension using health IT tools††

Innovations in Care Delivery

Millions of dollars in public and private funds have been leveraged to focus on improving the ABCS‡‡

** CMS Physician Compare and HRSA Uniform Data Set
†† Unpublished data from AMGA/MUPD and NACHC HIPS project
‡‡ CMS Million Hearts Risk Reduction Model, AHRQ EvidenceNOW, AHA Southwest Affiliate HTN project
Million Hearts Progress to Date

- Engagement and activation
- Clinical Quality Measure alignment
- Understand what works, where, and why
- Resources that help
- Extraordinary support for prevention
Million Hearts®
Hypertension Control Champions

• Practices and systems achieved control rates > 70%

• Champions used evidence-based strategies
  – Hypertension treatment protocols
  – Self-measured blood pressure monitoring
  – Frequent check-in’s
  – Registries and proactive outreach
  – Team-based care.

• Next Million Hearts® Hypertension Control Challenge planned for launch in Feb 2017

59 Champions
Representing
Solo to 70,000
Clinicians
Serving over 13
million people
>70% Control Rate
Standardizing Treatment through Protocols

• Hypertension Treatment Protocol
  Use is on the Rise
  – All Indian Health Service clinical settings
  – Many Federally Qualified Health Centers
  – Practices supported by CMS’ Quality Improvement Organizations

• Tobacco Treatment Protocol
  – Released a Tobacco Treatment Protocol in May
  – Customizable templates
  – Implementation guidance - coming in July
Million Hearts® Microsite for Clinicians

- Syndicated for your website audience
- Customized for your site’s size and color pallet
- Brand it with your logo
- Content is continuously maintained by CDC

The microsite and embed code will be available at https://tools.cdc.gov/medialibrary/index.aspx#/results
### What Must Happen To Prevent a Million?

#### Reduce Smoking
- 6.3M fewer smokers
  - Year-round media campaigns; pricing interventions
  - Targeted outreach to drive uptake of covered benefits
  - Systematic delivery of cessation services through use of cessation protocols, referrals to quit lines, and training of clinical staff
  - Widespread adoption of smoke-free space policies
  - Awareness of risks of second-hand smoke and the health benefits of smoke-free environments

#### Control Hypertension
- 10M more patients
  - Detection of those with undiagnosed hypertension
  - Systematic use of treatment protocols & other select QI tools
  - Practice of self-measured BP monitoring with clinical support
  - Recognition of high performers; dissemination of best practices
  - Connection of clinical & community resources to benefit people with HTN
  - Enhanced medication adherence
  - Intense focus on those with high burden and at high risk

#### Decrease Sodium Intake
- 20% reduction
  - Adoption of Healthy Food Service Guidelines
  - Voluntary sodium reduction and expansion of choices by food industry
  - Recognition of high performers and dissemination of best practices
  - Clear communication of the evidence supporting the health benefits of population-level sodium reduction

Events will also be prevented by improving aspirin use, cholesterol management, and utilization of cardiac rehab, and by eliminating artificial trans-fat consumption.
Focus of 2016

• **Smoking cessation**
  – Facilitate implementation of tobacco cessation protocols
  – Promote smoke-free spaces

• **Hypertension control**
  – Facilitate use of self-measured BP monitoring, treatment protocols, and processes to find the undiagnosed
  – Share best practices by promoting action guides that identify and control hypertension

• **Sodium reduction**
  – Advance adoption of procurement guidelines
  – Disseminate healthy eating resources
Focus of 2016

• Cholesterol management
  – Implement statin measure across clinical settings
  – Support partner actions currently underway

• Cardiac rehab
  – Facilitate collective actions to increase referral and participation

• Embed ABCS measures in value-based models

• Capture and tell the story of your success

• Recognize high performers & share best practices
  – Learn about the successes of the Hypertension Control Champions and share their lessons learned.
3 Phase Framework for Million Hearts
January 2016-July 2017

Primary Activities, Timelines, and Deliverables

Finishing Strong
January to December 2016
- Plant and push key actions
- Measure and report impact
- Collect and tell stories
- Celebrate

Cogent Final Report

Transition Zone
March 2016-July 2017
- Gather input from stakeholders
- Incorporate findings of evaluation and modeling
- Set framework, metrics, budget
- Engage partners, leadership
- Disseminate final report

Refreshed, Bold, Engaging Initiative

Million Hearts 2.0
January - July 2017 Launch
- Issue new aim and targets
- Ignite novel collaborations
- Gather powerful commitments
- Serially launch at events in 1st 6 months

Bigger, Deeper Impact
Million Hearts® Resources

- Hypertension Control: Change Package for Clinician
- Hypertension Treatment Protocols
- Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners
- Cardiovascular Health: Action Steps for Employers
- 100 Congregations for Million Hearts
- Million Hearts Healthy Eating & Lifestyle Resource Center
- Million Hearts® E-update
- Visit www.millionhearts.hhs.gov to find more resources
Thank You

Subscribe—and Contribute to the E-Update

Commit to key action steps

Work together to prevent heart attacks and strokes
Million Hearts®

Goal: Prevent 1 million heart attacks and strokes by 2017

- National initiative co-led by CDC and CMS in partnership with federal, state, and private sectors
- To address the causes of 1.5M events and 800K deaths a year, $316.6 B in annual health care costs and lost productivity and major disparities in outcomes
Q & A

Group Interaction
How does your work align with Million Hearts®?
Advancing Million Hearts in Rhode Island
RIDOH Programs
August 9, 2016

Jennifer Olsen-Armstrong, MS, RD
Chronic Care and Disease Management Team, RIDOH
Jennifer.Olsen@health.ri.gov
Million Hearts® Targets

Changing the Environment

- Reduce smoking
- Reduce sodium intake
- Eliminate trans fat intake

By 2017...

- The number of American smokers has declined from 26% to 24%
- Americans consume less than 2,900 milligrams of sodium each day
- Americans do not consume any artificial trans fat

Optimizing Care in the Clinical Setting

- Focus on the ABCS
- Use health tools and technology
- Innovate in care delivery

Aspirin use when appropriate

- Of the people who have had a heart attack or stroke, 70% are taking aspirin

Blood pressure control

- Of the people who have hypertension, 70% have adequately controlled blood pressure

Cholesterol management

- Of the people who have high levels of bad cholesterol, 70% are managing it effectively

Smoking cessation treatment

- Of current smokers, 70% get counseling and/or medications to help them quit

Stay Connected

- http://millionhearts.hhs.gov/be_one_mh.html
- facebook.com/MillionHearts
- twitter.com/@MillionHeartsUS
- millionhearts@cdc.gov

Million Hearts® promotes clinical and population-wide targets for the ABCS. The 70% values shown here are clinical targets for people engaged in the health care system. For the U.S. population as a whole, the target is 65% for the ABCS.
1 in 3 RI Adults has High Blood Pressure

Estimated # of RI adults with hypertension: 281,300

<table>
<thead>
<tr>
<th>In the U.S.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of hypertension</td>
<td>29.0%</td>
</tr>
<tr>
<td>% uncontrolled</td>
<td>53.5%</td>
</tr>
<tr>
<td>Of the uncontrolled, % unaware of having hypertension</td>
<td>40.0%</td>
</tr>
</tbody>
</table>
• 14 Practices
  – Federally Qualified Health Centers
  – Hospital Based Clinic
  – Free Clinic
• Work includes
  – Review data
  – Plan-Do-Study Act cycles
  – Network/ share
  – Submit progress reports
Rhode Island Chronic Care Collaborative

- Hypertension Control is a Priority
- Accurate Blood Pressure Measurement
- Evidence-based guidelines and protocols
- Facilitate Patient Self-Management
  - Goal Setting, Self-Measured Blood Pressure
- Team Based Care
- Technology
  - EMR assessment/ workflow analysis
Accurate Measurement

Are you ready for your big wedding?

Not really, there's so much to do—I am very nervous these days.
### Accurate Measurement

<table>
<thead>
<tr>
<th>Possible effect on systolic blood pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cuff too small</strong></td>
</tr>
<tr>
<td>*Most Frequent Error is wrong cuff size, especially too small</td>
</tr>
<tr>
<td><strong>Cuff too large</strong></td>
</tr>
<tr>
<td><strong>Cuff placed over clothing</strong></td>
</tr>
<tr>
<td><strong>Arm above heart level</strong></td>
</tr>
<tr>
<td><strong>Arm below heart level</strong></td>
</tr>
<tr>
<td><strong>Feet not flat on floor</strong></td>
</tr>
<tr>
<td><strong>Back not supported</strong></td>
</tr>
<tr>
<td><strong>Legs crossed</strong></td>
</tr>
<tr>
<td><strong>Patient doesn’t rest 5 minutes before</strong></td>
</tr>
<tr>
<td><strong>Patient talking</strong></td>
</tr>
<tr>
<td><strong>Full bladder</strong></td>
</tr>
<tr>
<td><strong>Tobacco or Caffeine Use</strong></td>
</tr>
</tbody>
</table>

Self-Measured Blood Pressure

• 5 RICCC practices focus on SMBP:
  – Provide BP monitor
    • Developed written agreements
  – Teach patient how to SMBP
    • Utilize AMA checklists
  – Provide Instruction on how to follow up
    • Frequency to take measurements
  – Record & utilize home measurements
Identify and develop a system to follow up with:

- Patients: ≥ 2 blood pressure readings ≥ 140 mmHg and/or ≥ 90 mmHg
  - 2 separate visits, including the most recent
- No diagnosis of hypertension

<table>
<thead>
<tr>
<th>Definition</th>
<th>Percent of patients who do not have a diagnosis of hypertension with two or more blood pressure readings ≥ 140 mmHg SBP and/or ≥ 90 mmHg DBP.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Patients in the denominator who have systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg at two separate medical visits, including the most recent visit, during the past 12 months.</td>
</tr>
<tr>
<td>Denominator</td>
<td>Active patients* age 18-85 years old who do not have a diagnosis of hypertension and were seen during the last 12 months.</td>
</tr>
</tbody>
</table>
| Exclusions                  | Patients less than 18 years of age
  - Patients diagnosed with Hypertension (ICD-9: 401.xx; ICD-10 codes: I10)
  - ESRD: ICD-9 code: 585.6x; ICD-10 code: N18.6 |
Well-Integrated Screening and Evaluation for WOMen Across the Nation

- CDC Funded Program
- Additional services for WCSP
  - Screenings, medical evaluation, health coaching, lifestyle programs
• Group visits for hypertension, diabetes, or CVD
• TEAMWorks Health Care Provider office
  – Provider (MD, PA, NP)
    • group presentation, and one-on-one with patient, if applicable
  – TEAMWorks pharmacist
    • individual assessment
  – TeamWorks dietitian
    • meets with each patient
Web-based Training Opportunities

Chronic Care and Disease Management Program Presents:

The Importance of Measuring Blood Pressure Accurately

Taking Action on Hypertension Control—Implementing the Million Hearts HTN Control Change Package

Protocols for Diagnosing Hypertension

Quality Improvement: How to Overcome Barriers
Community Health Workers

- Training on Hypertension & Diabetes

  - Initial focus is on CHW’s who work with health care practices
  - Community Health Workers will:
    - Support patients with high blood pressure/ diabetes
    - Refer patients to community resources
Coordinate Cessation Services

- Smokers’ Quitline 1-800-QUIT-NOW
- QuitWorks – Provider Based Referral System
- Community Health Network: Centralized Referral System
- Statewide Community Based Program for Uninsured
Impact of Different Factors on Risk of Premature Death

Source: Schroeder, SA (2007). We Can Do Better- Improving the Health of the American People. NEJM. 357:1221-8
“Public Health and Workplace Safety Act” passed in June 2004. Exemptions: Casinos, Smoking Bars, outdoor spaces such as beaches and parks.

- There is no risk-free level of exposure to secondhand smoke exposure. Secondhand Smoke is a US EPA Class A Carcinogen.

- Exposure to secondhand smoke leads to stroke, nasal irritation, lung cancer, coronary heart disease and reproductive issues in adults. SHS exposure is now known to increase the risk of strokes in nonsmokers by up to 30%.

- Secondhand smoke exposure is higher among people with low incomes. Most exposure to secondhand smoke occurs in homes and workplaces.

- Secondhand smoke drifts from unit to unit through air ducts, under doors, holes for piping, electrical outlets, wall and ceiling fixtures, exterior windows, and other pathways.

http://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke general_facts/
Live Smoke Free Program

Live Smoke Free Campaign launch 2011

- Campaign kick off using traditional and social media.
- Live Smoke Free web site with downloadable, property manager & resident toolkits, fact sheet and publications.
- Individual technical assistance for PHAs, boards, resident councils and affordable property management groups.
- No cost quarterly workshops for all property types.
- Scope expanded to include smoke free beaches, parks and tobacco free college campuses.

www.livesmokefree.ri.gov
Rhode Island Smoke Free Public Housing Authorities

As of 5/1/2015 Data Source: Rhode Island Tobacco Control Program

<table>
<thead>
<tr>
<th>Description</th>
<th>PHAs with smoke free policies</th>
<th>All PHAs in state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of PHAs</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Number of Units</td>
<td>9266</td>
<td>9467</td>
</tr>
<tr>
<td>Number of residents</td>
<td>15436</td>
<td>15686</td>
</tr>
</tbody>
</table>
HEZ are contiguous geographic areas that have measurable and documented health disparities, poor health outcomes, and identifiable social and environmental conditions to be improved.

- HEZ must be “small” enough so the plan of action/interventions can have a significant impact on the population (5K minimum)
Health Equity Zone (HEZ) Goals

- Improve health of communities with high rates of illness, injury, chronic disease, or other adverse health outcomes
- Improve birth outcomes
- Reduce health disparities
- Improve the social and environmental conditions of the neighborhood
- Support the development and implementation of policy and environmental change interventions
# Addressing Nutrition

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DAILY</th>
<th>3 MEALS, 2 SNACKS</th>
<th>3 MEALS, NO SNACK</th>
<th>PREPARATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,500-2,000 kcal (average low-average high)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL KCALS</td>
<td></td>
<td>550 kcal</td>
<td>175 kcal</td>
<td></td>
</tr>
<tr>
<td>SODIUM</td>
<td>≤ 2,000 mg</td>
<td>≤ 550 mg</td>
<td>≤ 175 mg</td>
<td>≤ 660 mg</td>
</tr>
<tr>
<td>CHOLESTEROL</td>
<td>≤ 250 mg</td>
<td>≤ 85 mg</td>
<td>≤ 28 mg</td>
<td>84 mg</td>
</tr>
<tr>
<td>CARBOHYDRATES</td>
<td>55% of daily caloric intake</td>
<td>50-80 g (1.5-2 oz)</td>
<td>15-30 g (0.5-1 oz)</td>
<td>100 g (≤ 3.5 oz)</td>
</tr>
<tr>
<td>DIETARY FIBER</td>
<td>≥ 30 g</td>
<td>≥ 7 g</td>
<td>≥ 4.5 g</td>
<td>&gt; 10 g</td>
</tr>
<tr>
<td>TOTAL FAT</td>
<td>30% of daily caloric intake</td>
<td>≤ 20 g</td>
<td>≤ 12 g</td>
<td>≤ 28 g</td>
</tr>
<tr>
<td>SATURATED Fat</td>
<td>≤ 10% of daily caloric intake for fat</td>
<td>≤ 2 g</td>
<td>≤ 1.2 g</td>
<td>≤ 3 g</td>
</tr>
<tr>
<td>TRANS FAT</td>
<td>0% added trans fats</td>
<td>0% added</td>
<td>0% added</td>
<td>0% added</td>
</tr>
<tr>
<td>LIQUID FATS AND OILS</td>
<td>2-3 tsp (34-45 g)</td>
<td>9-12 g</td>
<td>3.5-4.5 g</td>
<td>12-15 g</td>
</tr>
<tr>
<td>ADDED SUGAR</td>
<td>&lt; 5 Tbsp (75 g) per week</td>
<td>1 Tbsp (15 g) per day</td>
<td>none</td>
<td>1 Tbsp (15 g) per day</td>
</tr>
<tr>
<td>FRUITS &amp; VEGETABLES</td>
<td>12-16 oz (350-454 g) fruit, 20-24 oz (587-680 g) vegetables, variety of colors and types</td>
<td>8-10 oz (227-285 g)</td>
<td>4.5 oz (136-142 g)</td>
<td>11-13 oz (312-360 g)</td>
</tr>
</tbody>
</table>
QIN-QIOs

- CMS’s QIO Program Approach to Clinical Quality – Triple Aim:

- QIN-QIOs are regional, multistate entities providing services to 2 to 6 states for 5 year contracts

- Highly competitive proposal process - only 14 QIN-QIO contracts were awarded
New England QIN-QIO

• Two successful QIOs *pool expertise and resources* to engage beneficiaries and providers *in improving care, improving health and reducing costs* across New England

• Identified throughout six-state region as:
New England QIN-QIO

• Led and administered by Healthcentric Advisors
  – Focus areas: MA, ME, RI

• Partner – Qualidigm
  – Focus areas: CT, NH, VT
“You’ve got the blood pressure of a teenager – who lives on junk food, TV and the computer.”
Cardiac Health
Task Goals

Improve Cardiac Health implementing Million Hearts® ABCS:

- A spirin therapy
- B lood pressure control
- C holesterol control
- S moking cessation

• Reduce Cardiac Healthcare Disparities
Cardiac Health Task Goals

Increase Electronic Data Reporting

- Physician Offices
  - 8 practices (30 providers)
  - The Physician Quality Reporting System (PQRS)

- Home Health Agencies
  - 14 HHAs
  - HHQI National Cardiovascular Data Registry
Improvement Strategies

• Implement Team Care Model
• Data capture
• Actionable data analysis
• Workflow evaluation and redesign
• PDSAs to mitigate barriers
• Sharing Million Hearts & HHQI tools & resources
• Spreading best practices
Case Study

Internal Medicine practice

• EHR- PQRS reporting on HTN control
• PCMH
• 6 Providers
  – 5 providers scoring well above the state median (65%)
  – 1 provider scoring below state median (60%)
Interventions

• Team engagement
• Education on proper technique
• Correction to documentation
• BP at every visit not just annual exam
• Outreach calls for follow-up visits
• BP Action Plan Information sheets for pts
Case Example

HTN Control

Percentage

<table>
<thead>
<tr>
<th>Date</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/3/2015</td>
<td>60.60%</td>
</tr>
<tr>
<td>3/31/2016</td>
<td>67.20%</td>
</tr>
<tr>
<td>6/30/2016</td>
<td>75.60%</td>
</tr>
</tbody>
</table>
Sustainability

• Continue quarterly data analysis
• Continue BP at every visit
• Increase pt engagement
  – Shared decision making
  – Action plans
• Follow-up visits
• Team Engagement
Overview of the American Heart Association and Programs and Resources that align with Million Hearts®
Mission
Building healthier lives, free of cardiovascular diseases and stroke.

Our 2020 Impact Goal
By 2020 to improve the cardiovascular health of all Americans by 20% while reducing deaths from cardiovascular diseases and stroke by 20%.
Building a Culture of Health

A culture in which people live, work, learn, play and pray in environments that support healthy behaviors, timely quality care and overall well-being.
AHA and Million Hearts®
Spotlight on Rhode Island

Advocacy Priorities

• Healthier Food Choices in Public Places
• School Marketing
• Physical Education
• Bikeway Development
• Tobacco Control Funding
• Tobacco 21
AHA and Million Hearts® Spotlight on Rhode Island

Target BP

• Nationwide initiative to help healthcare providers and patients achieve better blood pressure control at the best levels to improve health

• Support physicians and care teams in helping their patients with high blood pressure reach a blood pressure goal of lower than 140/90 mm Hg, based on current AHA guidelines
AHA and Million Hearts®
Spotlight on Rhode Island

Target BP

• Health Impact: Driving toward moving 13.6 million individuals from uncontrolled to controlled blood pressure, through Federally Qualified Health Centers (FQHC) and clinics serving underserved/vulnerable populations and clinics within large healthcare systems.
AHA and Million Hearts® Spotlight on Rhode Island

Multicultural Health Priorities/Target BP

- Increase # of registered FQHCs and clinics
- Increase # of adult patients reached
AHA and Million Hearts®
Spotlight on Rhode Island

Multicultural Health Priorities/Target BP

• Face to Face meeting with clinical lead
• Provide trainings on Target: BP tools and resources
• Equip clinics with consumer education tools
• Connect clinics to community-based programs for self-monitoring like Check. Change. Control.
• Consulting services provided
• Clinical lead or team invited and attending workshop/webinar or hospital recognition event
The Guideline Advantage (TGA)

TGA Fact Sheet

• Million Hearts Measures in TGA: High Blood Pressure Control, Tobacco Use Screening, Tobacco Use Cessation Intervention, Ischemic Vascular Disease Use of Aspirin or Other Antithrombotic

• New as of Aug 8, 2016 – physicians at TGA participating practices may now receive Maintenance of Certification Improvement in Medical Practice (Part IV) credit for their engagement

Advantages to Practices & Physicians

• Qualified Clinical Data Registry (QCDR) and Specialized Clinical Data Registry for Meaningful Use Stage 2
• Comprehensive Data Assistance
• AHA Quality & Systems Improvement Consultation and expertise
• State-of-the-art population health management technology
• Clinic and system aggregation, with available physician-level reporting
• Tools for creating action lists
• Alignment with key national initiatives
• National and State Benchmarking
• Quality Improvement Community
Tools and Resources

• AHA online tools:
  – Heart 360
  – My Life Check®
  – Heart Attack Risk Calculator
• Sodium Leadership Community
• Multi-Cultural/Faith-based Initiatives: EmPowered to Serve
• Get With The Guidelines (TGA) hospital-based quality improvement program
• Communications
• Healthy Workplace Food & Beverage Toolkit
• You’re the Cure – www.yourethecure.org
Discussion

1. Is there a program you were unaware of that you would like to explore further for implementation or application in the state?

2. On which topics would you like additional information?

3. Other questions
Overview of the American Heart Association and Programs and Resources that align with Million Hearts®
Mission

Building healthier lives, free of cardiovascular diseases and stroke.

Our 2020 Impact Goal

By 2020 to improve the cardiovascular health of all Americans by 20% while reducing deaths from cardiovascular diseases and stroke by 20%.
Building a Culture of Health

A culture in which people live, work, learn, play and pray in environments that support healthy behaviors, timely quality care and overall well-being.
AHA and Million Hearts®
Spotlight on Idaho

Advocacy Priorities

• Health Insurance Coverage - Close the Gap
• Time Sensitive Emergencies - Stroke and STEMI Designations and Registries
• Healthy and Active Programs - Safe Routes to School, P.E.
• Tobacco Free – Smoke Free Air, Tobacco Free Idaho, Tobacco to 21
Advancing Million Hearts®:
AHA and Heart Disease and Stroke Prevention Partners Working Together in Idaho

July 27, 2016

Do you know THE FACTS ABOUT HBP?

HBP EFFECTS NEARLY 80 MILLION AMERICANS AND IS A LEADING FACTOR FOR HEART DISEASE AND STROKE
AHA | ASA 2020 Goal

AHA 2020 GOAL

Improve the CV health of all Americans by 20% while reducing deaths from CV diseases and stroke by 20%.

2010
Reduce CHD, stroke, and risk by 25%.

2020
Move 13.6 million Americans to control their HBP.
The Urgency Around High Blood Pressure Control

80 million adults have HBP

<table>
<thead>
<tr>
<th>Blood Pressure Category</th>
<th>Systolic (mmHg)</th>
<th>Diastolic (mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal / Ideal</td>
<td>less than 120</td>
<td>and less than 80</td>
</tr>
<tr>
<td>Prehypertension</td>
<td>120-139</td>
<td>or 80-89</td>
</tr>
<tr>
<td>Hypertension stage 1</td>
<td>140-159</td>
<td>or 90-99</td>
</tr>
<tr>
<td>Hypertension stage 2</td>
<td>160 or higher</td>
<td>or 100 or higher</td>
</tr>
<tr>
<td>Hypertensive crisis</td>
<td>higher than 180</td>
<td>or higher than 110</td>
</tr>
</tbody>
</table>

1 in 3 Americans is living with HBP today

Every 10 point drop in systolic BP is equivalent to a 30-50% drop in risk of cardiovascular disease & stroke.

AHA 2015 Statistical Update
The Urgency Around High Blood Pressure Control

HBP IS ONE OF THE MOST EXPENSIVE HEALTH CONDITIONS FOR U.S. EMPLOYERS

2001 TO 2011 HBP-related DEATHS INCREASED 13%

ESTIMATED DIRECT & INDIRECT COST OF HBP*

2011: $464 BILLION
2030: $274 BILLION

*Includes missed work days, cost of healthcare services and medication expenses.
BIG BET: REDUCE HIGH BLOOD PRESSURE

HEALTHY LIVING STRATEGIES (ESPECIALLY ↓ SODIUM) +

TARGET: BP/ THE GUIDELINE ADVANTAGE

FIELD STAFF & STATE DOH DRIVE ALGORITHM

STRATEGIC ALLIANCES (AMGA, AMA, ETC.)

AFFORDABLE CARE ACT

MEDICAID EXPANSION

HEADCINDS

TALLWINDS

SPRINT STUDY RESULTS

COMMUNITY PLAN 2.0

EHR INCENTIVE PROGRAM MEASURES

COMPLEMENTARY STRATEGIES

COMPLEMENTARY STRATEGIES

COMPLEMENTARY STRATEGIES

BIG BETS

HBP TREATMENT ALGORITHM IN CLINICS

BIG BETS

COMMUNITY CONNECTIONS TO CLINICS

BIG BETS

INCREASE ACCESS TO CARE

BI Big bets

FEDERAL REGULATIONS INCENTIVIZING HCP’S TO BETTER PERFORMANCE

PQRS 2016

CORE QUALITY MEASURES COLLABORATIVE DECISION TO INCLUDE DUAL MEASURES FOR BP CONTROL

COMMUNITY CONNECTIONS IN CLOSED SYSTEMS

RETAIL PHARMACY STRATEGIES
Check. Change. Control.™
Building a Sustainable HBP Program

Clinical Pharmacists
2008 – 2010
- Remote Monitoring Study via Kaiser Clinical Pharmacists
- Six month SBP control significantly higher than control group. Suggests healthcare cost saving

Community Settings
2010 - 2011
- Check It. Change It. Community-based intervention in Durham County
- In patients that began the study with a BP of > 150/90, systolic BP decreased by 24.2 mmHg and diastolic BP decreased by 10 mmHg.

Enlisting Partners
2012 - Present
- AHA joined with Million Hearts to host a forum that included partners across industries positioned to impact the issue of HBP
- Initial meeting was the impetus for the launch of AHA’s HBP Leadership Community based on attendees’ desire to continue the innovation, sharing and exchange of solutions

Innovation in the Field
2012 - 2013
- Check It. Change It. set the stage for larger, community-based model run by the AHA focused on high-risk pop.
- Grants to local market staff designated for rapid development, execution and testing of programs using partners and volunteers.
- Similar results to Check It. Change It. Lowering BP by 5 mmHG, with more significant drops between 11mmHG and 26 mHG in high risk groups
Why it Works: Key Evidence-Based Scientific Principles

Self Monitoring Makes a Difference
Proven track record for taking blood pressure readings at home or outside of the healthcare provider office setting.

- Use of digital self-monitoring and communication tool
- Charting & tracking improves self-management skills related to blood pressure management

Personal Interaction Makes a Difference
Health mentors can motivate and encourage participants.

Multicultural Program Investments Make a Difference
Hypertension creates a health disparity for African-Americans.
Program Components

Community Partners with Shared Goals to Drive BP Control

Since August, 2012 over 46,000 participants have enrolled in Heart360

Campaign Results*:
Average drop in Systolic BP: 11.02 mm Hg
Average drop in Diastolic BP: 7.68 mm Hg

Innovative Implementation Across Markets

Central BP Tracking Tool for Participant Engagement and Data Collection

Health Mentors Encourage Participants to Track Weekly Readings for 4 Months
Benefits extend even with partial engagement:

Even those participants who did not meet the full retention criteria saw declines in BP numbers.

WHAT DO THESE RESULTS MEAN?

Also, a 5mmHg reduction in systolic blood pressure would increase the prevalence of ideal blood pressure from 44.26% to 65.31%
**Target: BP** is a national movement aimed at improving blood pressure control, to reduce the number of Americans who have heart attacks and strokes. **Target: BP** provides physician practices and health systems resources and support to achieve a 70% blood pressure control rate with a target of achieving 80% or higher.
Why launch Target: BP now?

- SPRINT study results
- Increased access to care
- Policies incentivize HCP’s to better control
- AHA 2020 goals are imminent
- Synergizing with Million Hearts program
What is Target: BP?

A call to action motivating hospitals, medical practices, practitioners and health services organizations to prioritize blood pressure control.

Recognition for healthcare providers who attain high levels of blood pressure control in their patient populations, particularly those who achieve 70 or 80 percent control.

A source for tools and assets for healthcare providers to use in practice, including the AHA/ACC/CDC Hypertension Treatment Algorithm and the AMA’s M.A.P. Checklist.
Tools & Resources for Successful Control

The 2015 M.A.

Measure accurate

Protocols to guide evidence-based prescribing

Did you know?
National experts recommend that clinical teams use hypertension treatment protocols to manage patients with hypertension. Just as a football team’s playbook describes what players should do during a play, a treatment protocol clearly spells out what a care team should do.

Why are protocols important?
Studies show that getting blood pressure under control quickly reduces the risk for heart attack, strokes and even death. Treatment protocols help clinicians and staff work together as a team to identify which patients to treat, when to treat them, what medications to use, what the target blood pressure should be and how often follow-up should occur. However, it is important to note that clinicians should not use a protocol to replace sound medical decision making for a given patient’s unique situation.

Where can you find examples of evidence-based treatment protocols to use?
If your organization has not already developed an evidence-based treatment protocol, the Million Hearts® Initiative has a webpage containing several examples of evidence-based treatment protocols for improving blood pressure control. Located at http://www.millionhearts.gov/protocols.html, these evidence-based treatment protocols help the clinical team to address:

- When patients should receive treatment
- Establish treatment initiation cut points—In the case of the Million Hearts® initiative protocol for controlling hypertension in adults, the treatment initiation cut off is set at a pre-hypertension level for most patients.
- What evidence-based treatment patients should receive
- Evidence-based lifestyle changes—such as losing weight, using the dietary approaches to stop hypertension (DASH) eating plan or engaging in regular aerobic exercise—can reduce a patient’s systolic blood pressure by 5-15 mmHg.
- Four medication classes are recommended for most patients: thiazide diuretics, calcium channel blockers, and either an ACE inhibitor or ARB, but not both.
- Single-pill combination therapy is recommended for patients with high blood pressure, especially those with a blood pressure of 160/100 mm Hg or higher.
- Most patients should target a blood pressure of less than 140/90 mm Hg.
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- How a provider or patient should follow-up after treatment begins
- Early and frequent follow-up (monthly to bimonthly) is recommended so that patients can be adapted to modify or adjust the treatment plan. If treatment until their blood pressure is controlled.
- Follow-up for high blood pressure in the treatment.
- Keep in mind that follow-up does not always have to occur with a primary care provider. Many practices or health centers have built successful follow-up programs around well measured blood pressure monitoring as part of the blood pressure care with medical assistants or nurses.

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Elements Associated with Effective Adoption of Protocols

Practice Team-Base Care

• Make hypertension control a priority.
• Fully use the expertise and scope of practice of every member of the health care team.
• Include the patient and family as key members of the team.
• Learn about community resources and recommend them to patients.
• Conduct pre-visit planning to make the most of the care encounter.
• Look for opportunities to check in with patients between visits and adjust medication dose as needed.
Tools and Resources

Online Tools
- Heart 360
- My Life Check
- Heart Attack Risk Calculator
- High Blood Pressure Risk Calculator
- AHA’s Smoking Cessation Tools and Resources
- AHA Healthy Workplace Food and Beverage Toolkit July 2016

Resources
- EmPowered to Serve
- Get With The Guidelines
- Check.Change.Control
Discussion

1. Is there a program you were unaware of that you would like to explore further for implementation or application in the state?

2. On which topics would you like additional information?

3. Other questions
LUNCH BREAK
Partners, Programs and Persons That Align
Ways to Work Together
and
Next Interactions
How did this meeting benefit you and your organization?

Do you have suggestions on improving the overall format for this meeting?
Thank you for your participation!