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®

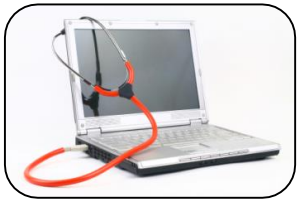
Keeping Us Healthy
Changing the environment

Health Disparities

Excelling in the ABCS
Optimizing care

Focus on the **ABCS**

Health tools and technology



Innovations in care delivery

Million Hearts®

Glantz. Prev Med. 2008; 47(4): 452-3.
How Tobacco Smoke Causes Disease: A Report of the Surgeon General, 2010.

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

Intervention	Pre-Initiative Estimate 2009-10	2017 Target
Smoking prevalence*	26%	24%
Sodium reduction	3580 mg/day	2900 mg/day
Trans fat reduction	0.6% of calories	0% of calories

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

National Survey on Drug Use and Health, National Health and Nutrition Examination Survey

Getting to a Million by 2017: *Targets for the ABCS*

Intervention	Pre-Initiative Estimate 2009-2010	2017 Population-wide Goal	2017 Clinical Target
Aspirin when appropriate	54%	65%	70%
Blood pressure control	52%	65%	70%
Cholesterol management	33%	65%	70%
Smoking cessation	22%	65%	70%

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

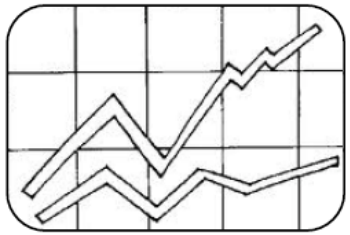
Accomplished: FDA issued the final determination on artificial trans fat§

* 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

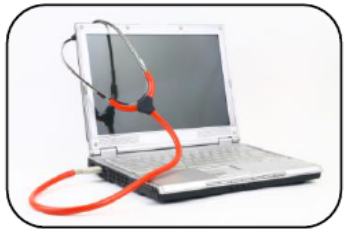
Optimizing Care in the Clinical Setting

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

59 Champions

Representing Solo to 70,000 Clinicians

Serving over 13 million people

>70% Control Rate

- 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***

Million Hearts®

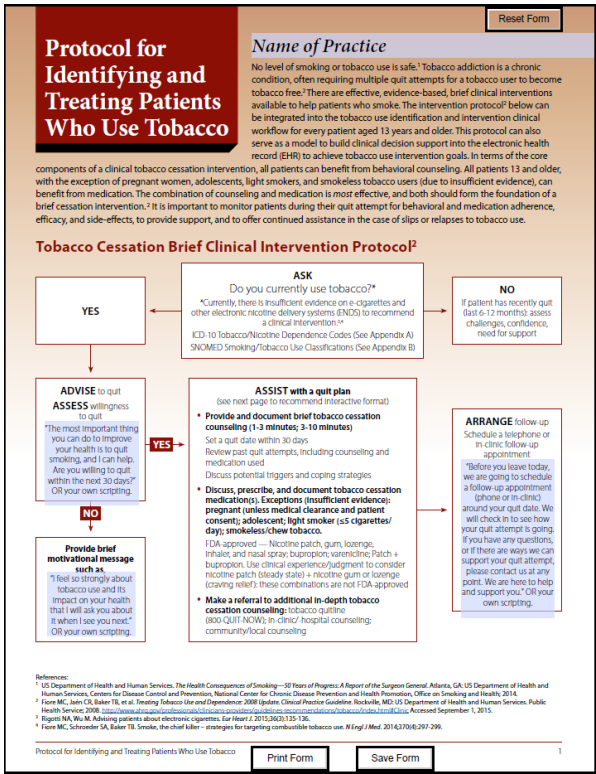
Standardizing Treatment through Protocols

- 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



Protocol for Identifying and Treating Patients Who Use Tobacco

Reset Form

Name of Practice

No level of smoking or tobacco use is safe.[1] Tobacco addiction is a chronic condition, often requiring multiple quit attempts for a tobacco user to become tobacco free.[2] There are effective, evidence-based, brief clinical interventions available to help patients who smoke. The intervention protocol[2] below can be integrated into the tobacco use identification and intervention clinical workflow for every patient aged 13 years and older. This protocol can also serve as a model to build clinical decision support into the electronic health record (EHR) to achieve tobacco use intervention goals. In terms of the core components of a clinical tobacco cessation intervention, all patients can benefit from behavioral counseling. All patients 13 and older, with the exception of pregnant women, adolescents, light smokers, and smokeless tobacco users (due to insufficient evidence), can benefit from medication. The combination of counseling and medication is *most* effective, and both should form the foundation of a brief cessation intervention.[2] It is important to monitor patients during their quit attempt for behavioral and medication adherence, efficacy, and side-effects, to provide support, and to offer continued assistance in the case of slips or relapses to tobacco use.

Tobacco Cessation Brief Clinical Intervention Protocol[2]

YES

ASK
Do you currently use tobacco?*
*Currently, there is insufficient evidence on e-cigarettes and other electronic nicotine delivery systems (ENDS) to recommend a clinical intervention.[3,4]
ICD-10 Tobacco/Nicotine Dependence Codes (See Appendix A)
SNOMED Smoking/Tobacco Use Classifications (See Appendix B)

NO
If patient has recently quit (last 6-12 months): assess challenges, confidence, need for support

ADVISE to quit
ASSESS willingness to quit
"The most important thing you can do to improve your health is to quit smoking, and I can help. Are you willing to quit within the next 30 days?"
OR your own scripting.

YES

ASSIST with a quit plan
(see next page to recommend interactive format)
- **Provide and document brief tobacco cessation counseling (1-3 minutes; 3-10 minutes)**
  Set a quit date within 30 days
  Review past quit attempts, including counseling and medication used
  Discuss potential triggers and coping strategies
- **Discuss, prescribe, and document tobacco cessation medication(s). Exceptions (insufficient evidence): pregnant (unless medical clearance and patient consent); adolescent; light smoker (≤5 cigarettes/day); smokeless/chew tobacco.**
  FDA-approved — Nicotine patch, gum, lozenge, inhaler, and nasal spray; bupropion; varenicline; Patch + bupropion. Use clinical experience/judgment to consider nicotine patch (steady state) + nicotine gum or lozenge (craving relief); these combinations are not FDA-approved
- **Make a referral to additional in-depth tobacco cessation counseling:** tobacco quitline (800-QUIT-NOW); in-clinic/ hospital counseling; community/local counseling

ARRANGE follow-up
Schedule a telephone or in-clinic follow-up appointment
"Before you leave today, we are going to schedule a follow-up appointment (phone or in-clinic) around your quit date. We will check in to see how your quit attempt is going. If you have any questions, or if there are ways we can support your quit attempt, please contact us at any point. We are here to help and support you." OR your own scripting.

NO

Provide brief motivational message such as,
"I feel so strongly about tobacco use and its impact on your health that I will ask you about it when I see you next."
OR your own scripting.

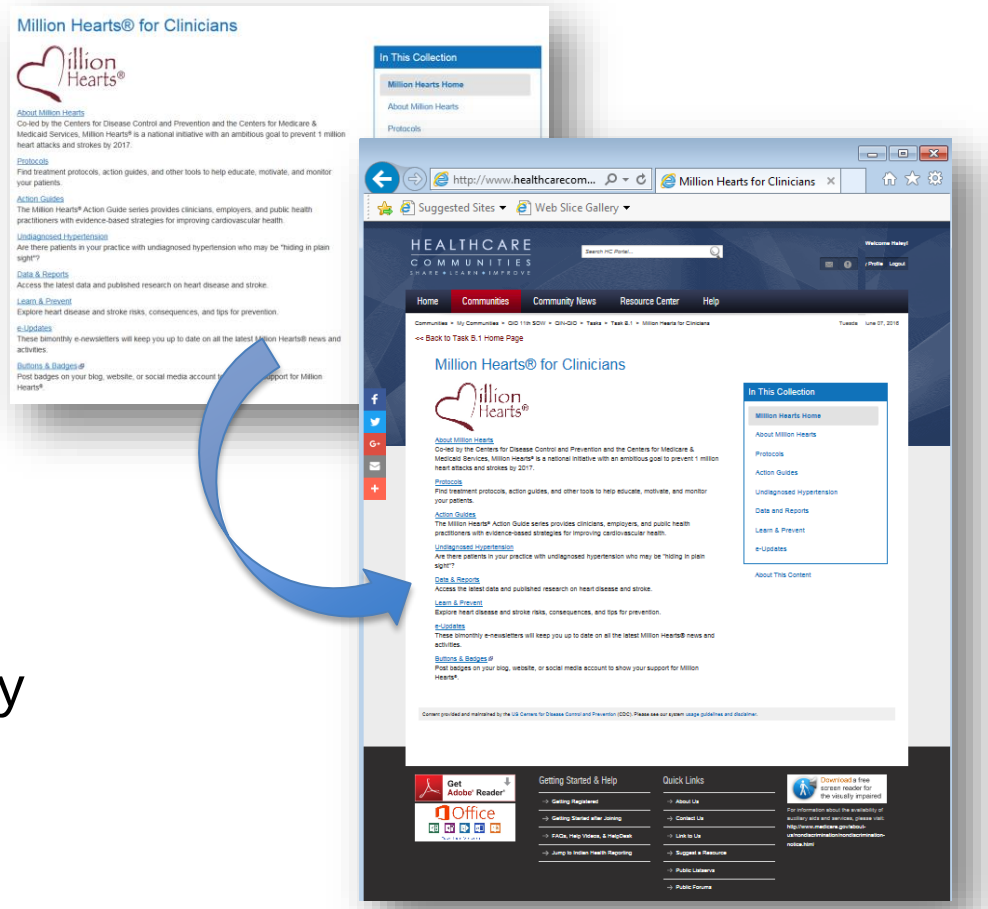
References:
1 US Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2014.
2 Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline*. Rockville, MD: US Department of Health and Human Services. Public Health Service; 2008. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html#Clinic Accessed September 1, 2015.
3 Rigotti NA, Wu M. Advising patients about electronic cigarettes. *Eur Heart J*. 2015;36(3):135-136.
4 Fiore MC, Schroeder SA, Baker TB. Smoke, the chief killer – strategies for targeting combustible tobacco use. *N Engl J Med*. 2014;370(6):297-299.

Protocol for Identifying and Treating Patients Who Use Tobacco 1

Print Form Save Form

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

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

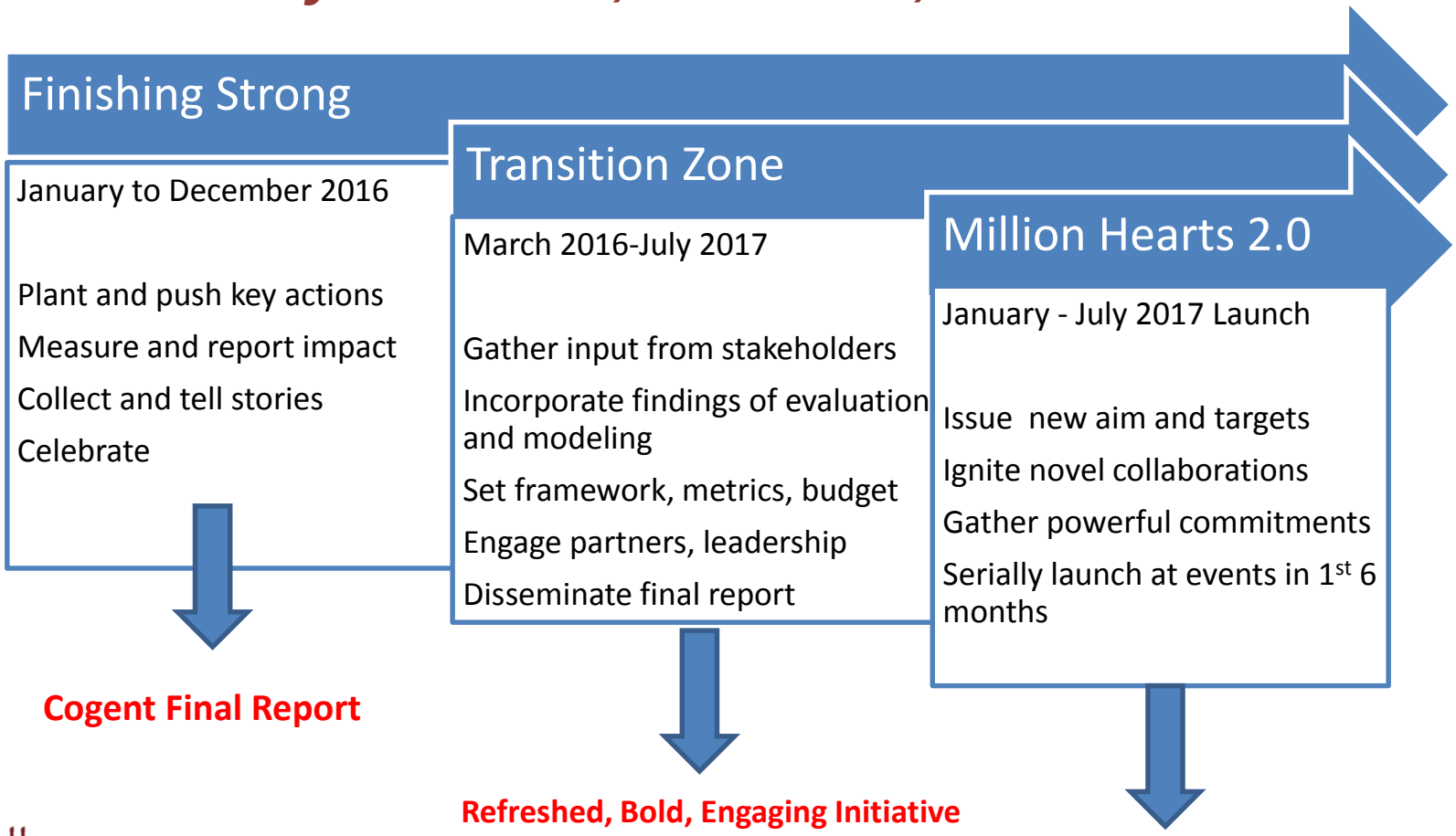
Focus of 2016

- 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



Million Hearts®

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

Million Hearts®

Thank You

Million Hearts®

Subscribe—and Contribute to the E-Update

Commit to key action steps

Work together to prevent heart attacks and strokes

Million Hearts® @MillionHeartsUS CDC StreamingHealth

The Million Hearts® Initiative

Robin Rinker, MPH, CHES
Health Communication Specialist

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®?


RHODE ISLAND
DEPARTMENT OF HEALTH

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 (Na)

Eliminate trans fat intake (TRANS FAT)

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

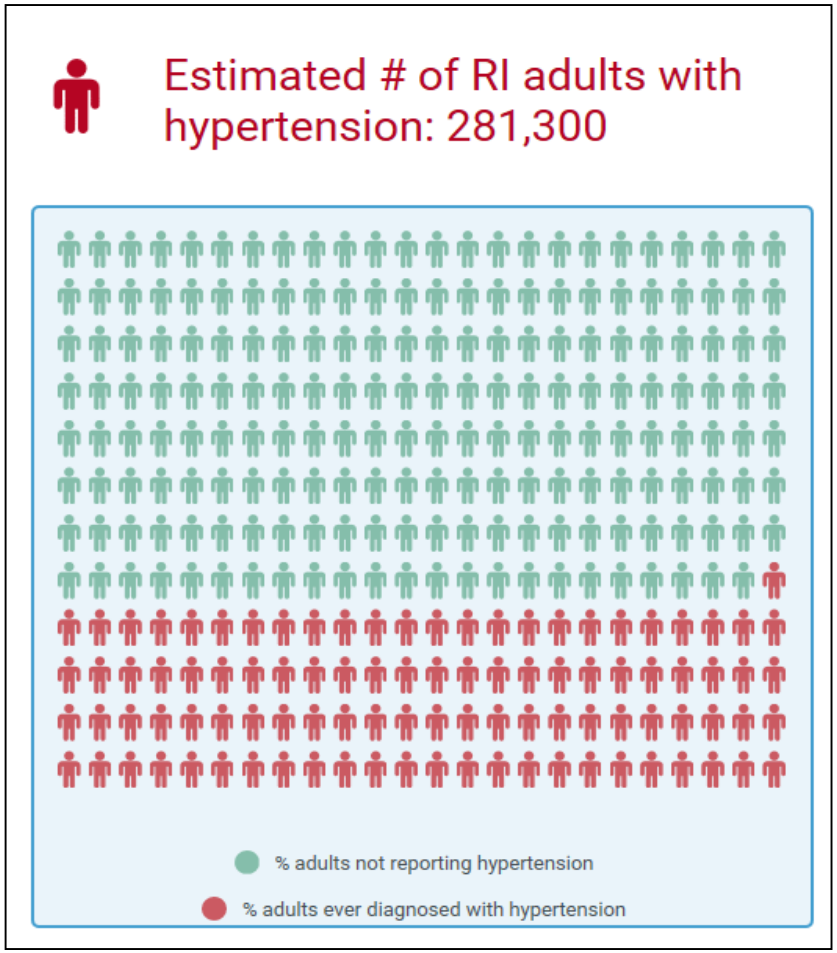
facebook.com/MillionHearts

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



In the U.S.	
Prevalence of hypertension	29.0%
% uncontrolled	53.5%
Of the uncontrolled, % unaware of having hypertension	40.0%

Rhode Island Chronic Care Collaborative

- 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

Accurate Measurement

	Possible effect on systolic blood pressure
Cuff too small*	+10-40 mm HG *Most Frequent Error is wrong cuff size, especially too small
Cuff too large *	-5-25 mm HG
Cuff placed over clothing	+/- 10-40 mm HG
Arm above heart level	+2 mm/ hg per inch above heart level
Arm below heart level	+ 2 mm/ hg per inch above heart level
Feet not flat on floor	+ 5 – 15 mm/hg
Back not supported	+6 mg/HG (diastolic)
Legs crossed	+ 5-8 mm/HG
Patient doesn't rest 5 minutes before	+ 10-20 mm/Hg
Patient talking	+10- 15 mm/Hg
Full bladder	+10- 15 mm/Hg
Tobacco or Caffeine Use	+6-11 mm/Hg

Source: Improving the Screening, Prevention and Management of Hypertension. An Implementation tool for Clinical Practice Teams. Washington State Department of Health.

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

Undiagnosed Hypertension

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

Definition	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.
Numerator	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.
Denominator	Active patients* age 18-85 years old who do not have a diagnosis of hypertension and were seen during the last 12 months.
Exclusions	Patients less than 18 years of age • **Patients diagnosed with Hypertension** (ICD-9: 401.xx; ICD-10 codes: I10) • Pregnancy (ICD-9 codes – 630.xx-679.xx, V22.xx, V23.xx, V28.xx; ICD-10 codes: O00.1 – O9A.519, Z33-Z36) • ESRD: ICD-9 code: 585.6x; ICD-10 code: N18.6

WISEWOMAN

Well-Integrated Screening and Evaluation for WOMen Across the Nation

-CDC Funded Program

-Additional services for WCSP

-Screenings, medical evaluation, health coaching, lifestyle programs

TEAMWorks

- 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

Chronic Care and Disease Management Program Presents:

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

Chronic Care and Disease Management Program Presents:

Protocols for Diagnosing Hypertension

Chronic Care and Disease Management Program Presents:

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

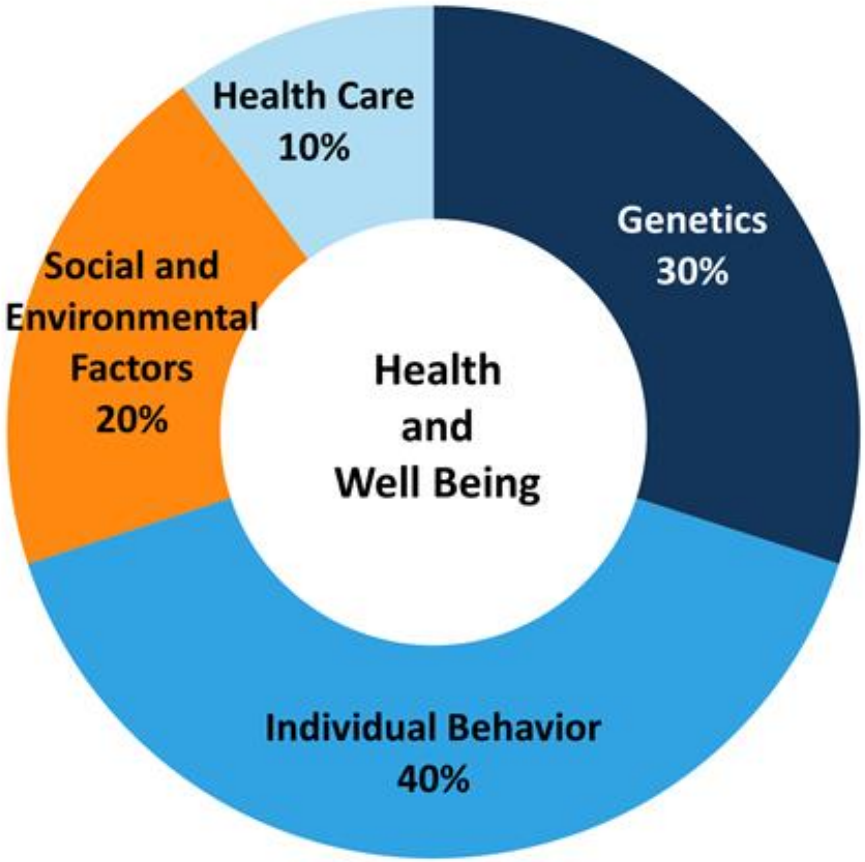
Coordinate Cessation Services

- Smokers' Quitline 1-800-QUIT-NOW
- QuitWorks – Provider Based Referral System
- Community Health Network: Centralized Referral System
- Statewide Community Based Program for Uninsured

HARD, YES. IMPOSSIBLE, NO.

Insured or uninsured, trying to quit or helping a smoker quit, we can help.

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
Located at: http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Rhode Island Smoke Free Public Places & Workplaces Law

"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/
http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/DOH_3628.pdf

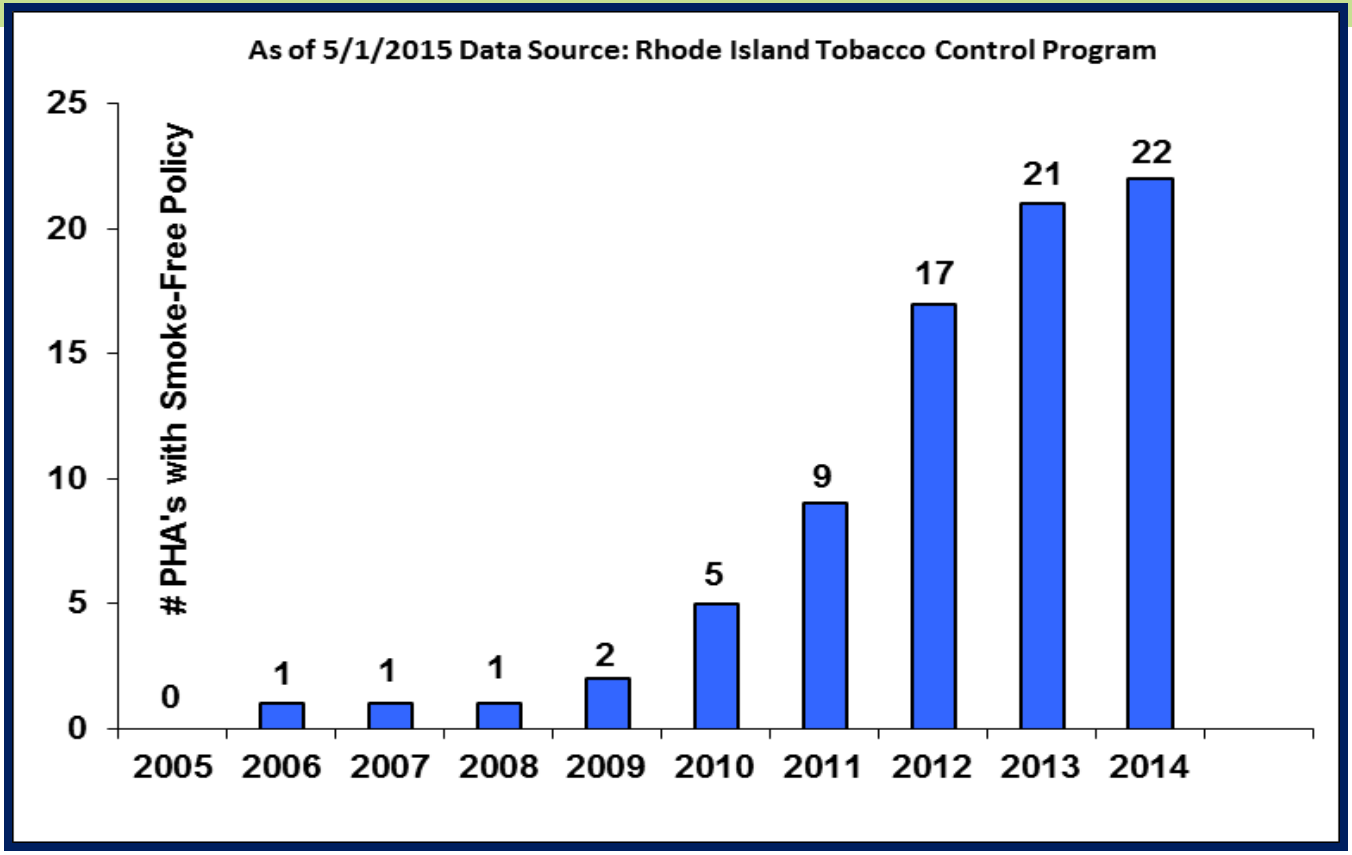
Live Smoke Free Program

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



Description	PHAs with smoke free policies	All PHAs in state
Number of PHAs	22	25
Number of Units	9266	9467
Number of residents	15436	15686

Health Equity Zone (HEZ) Goals

- Defined geographic location; place-based
- Use of local assessments to establish baseline;
- Community assets mapping and community readiness;
- Collective impact framework;
- Sustainability

- 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

CATEGORY	DAILY	3 MEALS, 2 SNACKS		3 MEALS, NO SNACK	PREPARATION
		PER MEAL	PER SNACK	PER MEAL	
TOTAL KCALS	1,500-2,000 kcals (average low-average high)	550 kcals	175 kcals	670 kcals	The daily recommended intake is 3 meals, 2 snacks with calories (kcals) distributed evenly across meals (breakfast, lunch, and dinner). Meal breakdown recommendations are based on a 2,000 kcal diet.
SODIUM	≤ 2,000 mg	≤ 550 mg	≤ 175 mg	≤ 660 mg	Avoid processed and preserved foods to limit sodium levels. Utilize spices and fresh herbs as much as possible.
CHOLESTEROL	≤ 250 mg	≤ 65 mg	≤ 28 mg	84 mg	Replace or eliminate high cholesterol foods in your recipe with lower cholesterol options like egg whites and lean cuts of meat.
CARBOHYDRATES	55% of daily caloric intake (210-275 g for 1500-2000 kcal diet)	50-60 g (1.5-2 oz)	15-30 g (0.5-1 oz)	100 g (≤ 3.5 oz)	When at all possible, use complex carbohydrates; no fried, high sugar foods.
DIETARY FIBER	≥ 30 g	≥ 7 g	≥ 4.5 g	≥ 10 g	Choose ingredients high in fiber whenever possible.
TOTAL FAT	30% of daily caloric intake (50-67 g for 1500-2000 kcal diet)	≤ 20 g	≤ 12 g	≤ 28 g	Using low-fat proteins and finishing with fats that are liquid at room temperature helps to reduce the total fat in a dish.
SATURATED FAT	≤ 10% of daily caloric intake for fat (5-7 g for 1500-2000 kcal diet)	≤ 2 g	≤ 1.2 g	≤ 3 g	Low saturated fat items should be used whenever possible substitute liquid fats and oils listed below when possible.
TRANS FAT	0% added trans fats	0% added	0% added	0% added	Certain foods naturally contain trans fats; additional trans fats should not be added due to associated increase of LDL cholesterol.
LIQUID FATS AND OILS	2-3 tsp (34-45 g)	9-12 g	3.5-4.5 g	12-15 g	Use monunsaturated, and polyunsaturated fats like olive, peanut, canola, corn, soybean, safflower, and sesame oils.
ADDED SUGAR	< 5 Tbsp (75 g) per week	1 Tbsp (15 g) per day	none	1 Tbsp (15 g) per day	Limit added sugars to any meal. If needed, add sugar to one meal in total menu for day.
FRUITS & VEGETABLES	12-16 oz (350-454 g) fruit, 20-24 oz (567-680 g) vegetables, variety of colors and types	8-10 oz (227-285 g)	4-5 oz (136-142 g)	11-13 oz (312-369 g)	50% of meal should be a variety of colorful, low starch fruits and/or vegetables. Potatoes, corn, and other starchy vegetables should be counted as carbohydrates.

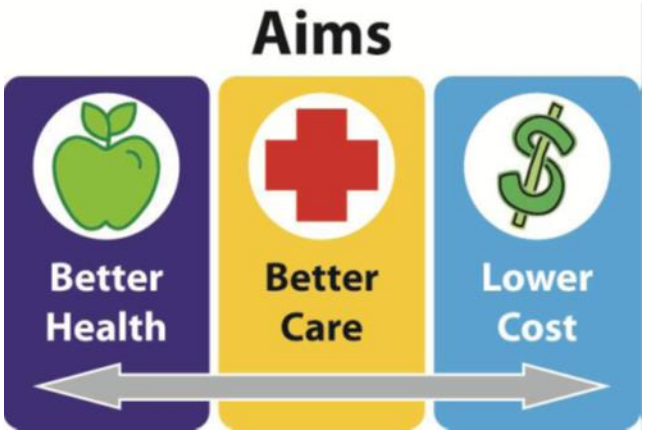

RHODE ISLAND
DEPARTMENT OF HEALTH

HEALTHCENTRIC ADVISORS

Brenda Jenkins

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**

This material was prepared by the New England Quality Innovation Network-Quality Improvement Organization (QIN-QIO), the Medicare Quality Improvement Organization for New England, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOWQIN-B1_201608_0678

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

NEW ENGLAND QUALITY INNOVATION NETWORK
Administered By Healthcentric Advisors in Partnership with Qualidigm

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

Cardiac Health

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

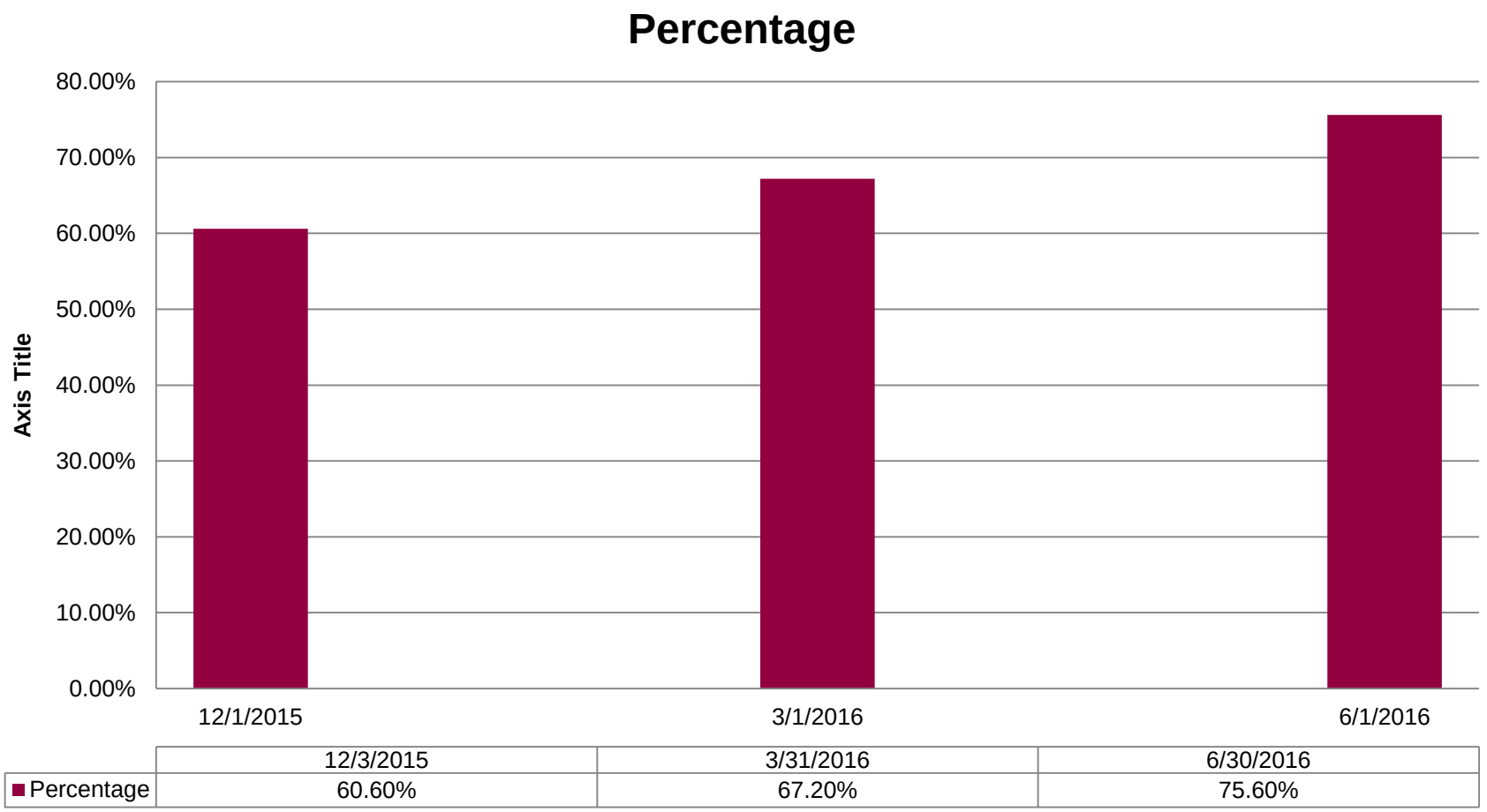
Internal Medicine practice

- 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



	12/3/2015	3/31/2016	6/30/2016
Percentage	60.60%	67.20%	75.60%

Sustainability

- Continue quarterly data analysis
- Continue BP at every visit
- Increase pt engagement
  - Shared decision making
  - Action plans
- Follow-up visits
- Team Engagement

Q & A

Overview of the American Heart Association and Programs and Resources that align with Million Hearts®

American Heart Association | American Stroke Association

life is why™

American Heart Association | American Stroke Association
life is why™

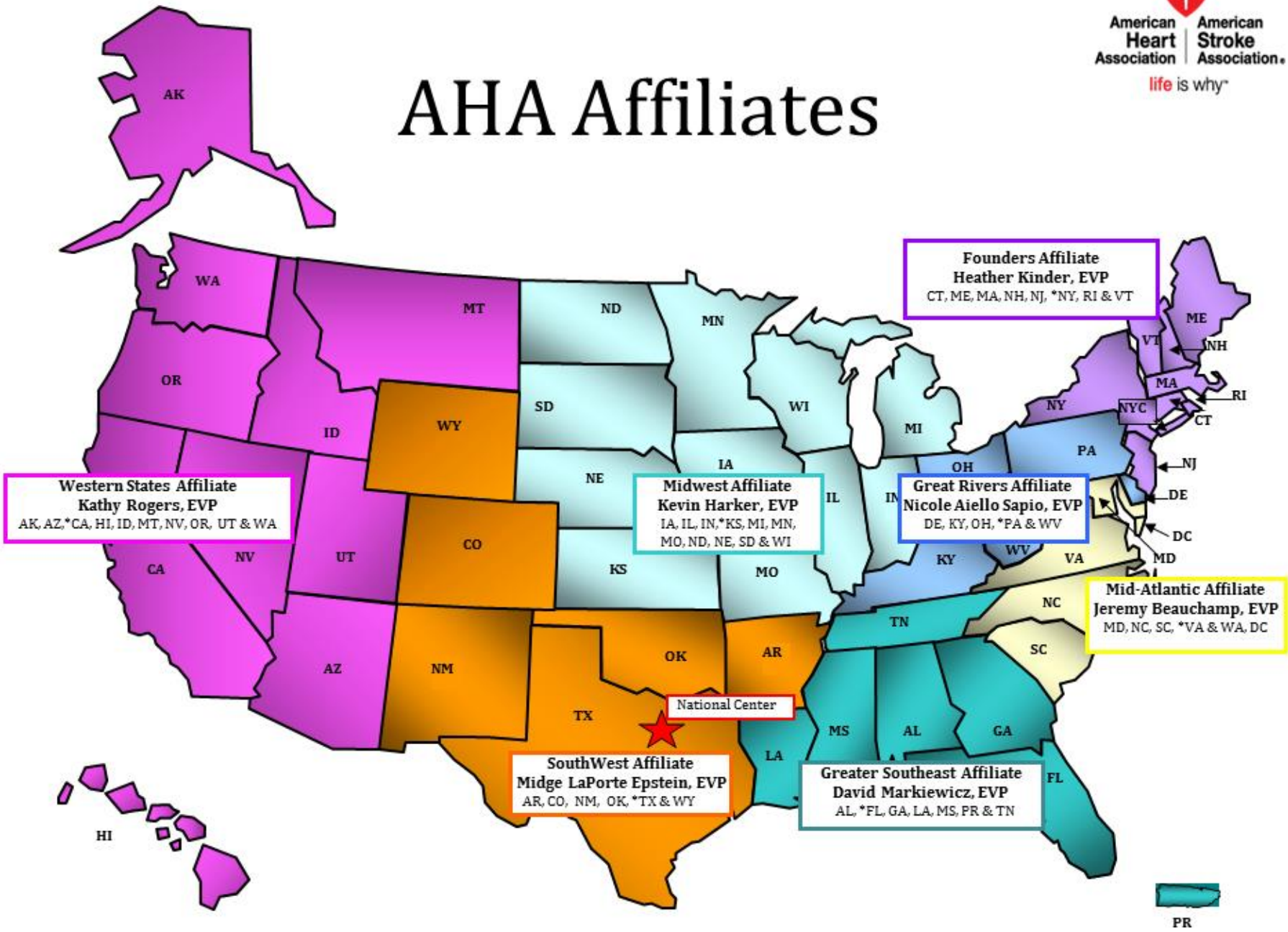
Mission

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%.

AHA Affiliates



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

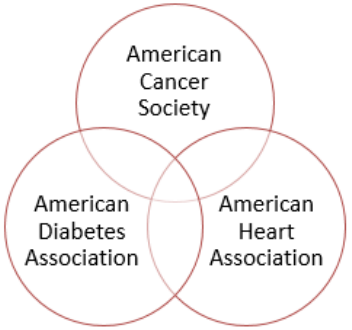
Multicultural Health Priorities/Target BP

- 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)

THE GUIDELINE ADVANTAGE

The Tri-Agency Relationship



- A joint program of the American Cancer Society, the American Diabetes Association, and the American Heart Association
- Each organization has long developed scientific statements and guidelines specific to prevention and disease management
- Shared goals:
  - Sets national goals and objectives that compliment their guidelines
  - Common interest in translating those guidelines into practice

THE GUIDELINE ADVANTAGE

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

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

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®

American Heart Association | American Stroke Association

life is why™

Mission

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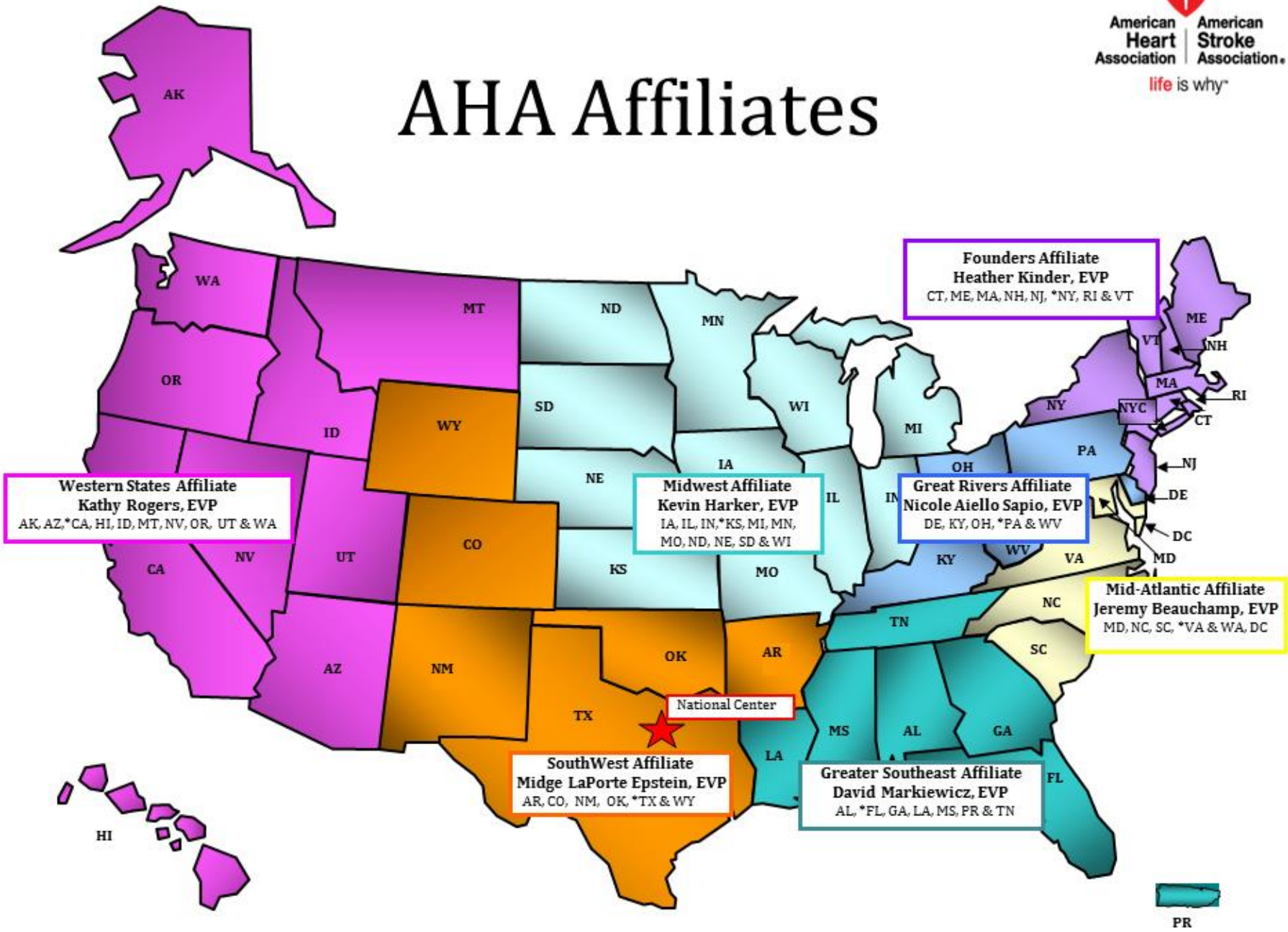
Our 2020 Impact Goal

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

AHA Affiliates



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

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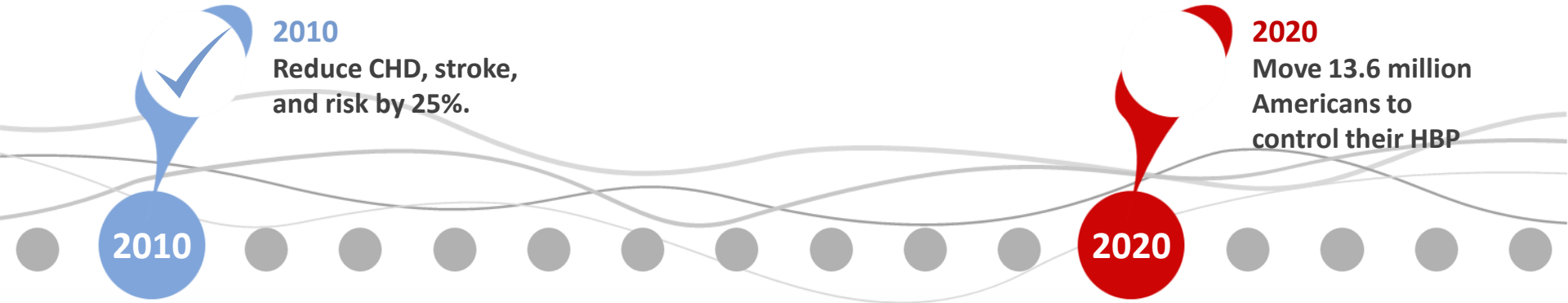
AHA | ASA 2020 Goal

AHA 2020 GOAL

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



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The Urgency Around High Blood Pressure Control

- 80 million adults have HBP

1 IN 3 AMERICANS IS LIVING WITH HBP TODAY

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

EVERY **10 POINT DROP** in systolic BP

≈

30-50% drop in risk of cardiovascular disease & stroke.

AHA 2015 Statistical Update

American Heart Association | American Stroke Association

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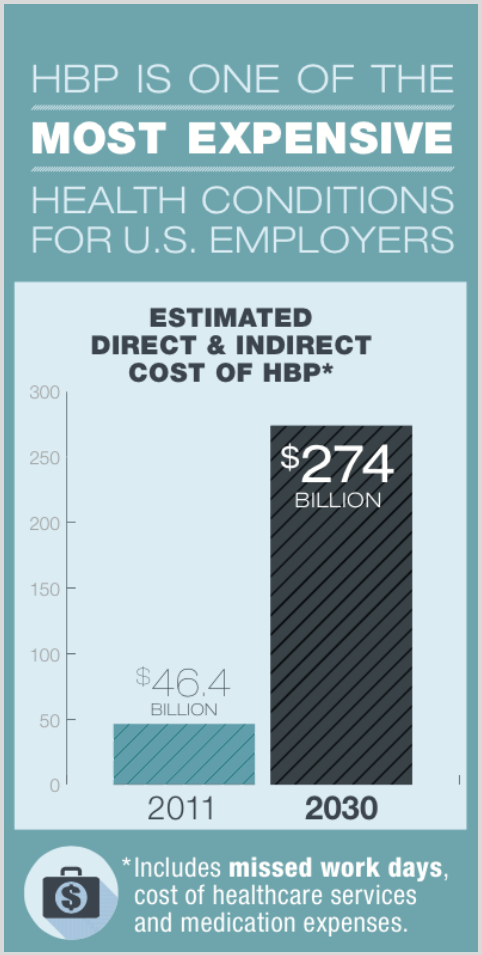
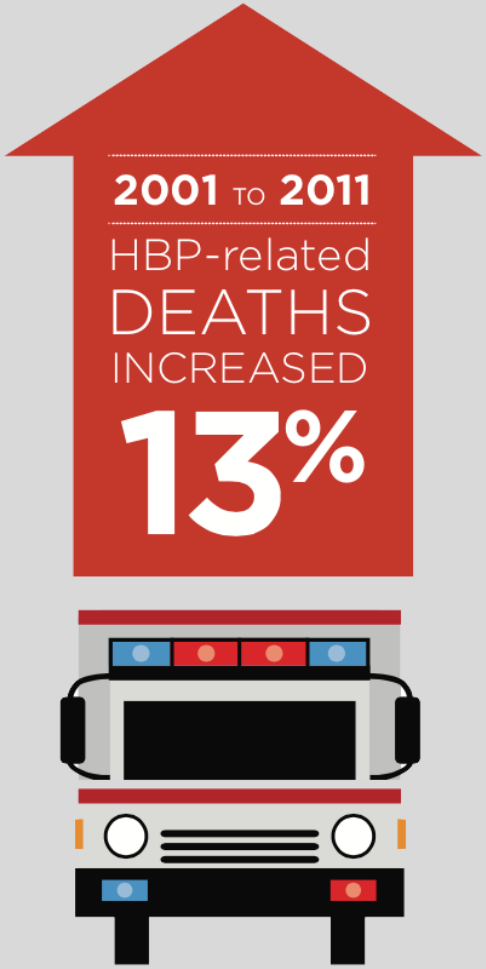
The Urgency Around High Blood Pressure Control





AHA 2015 Statistical Update

American Heart Association | American Stroke Association
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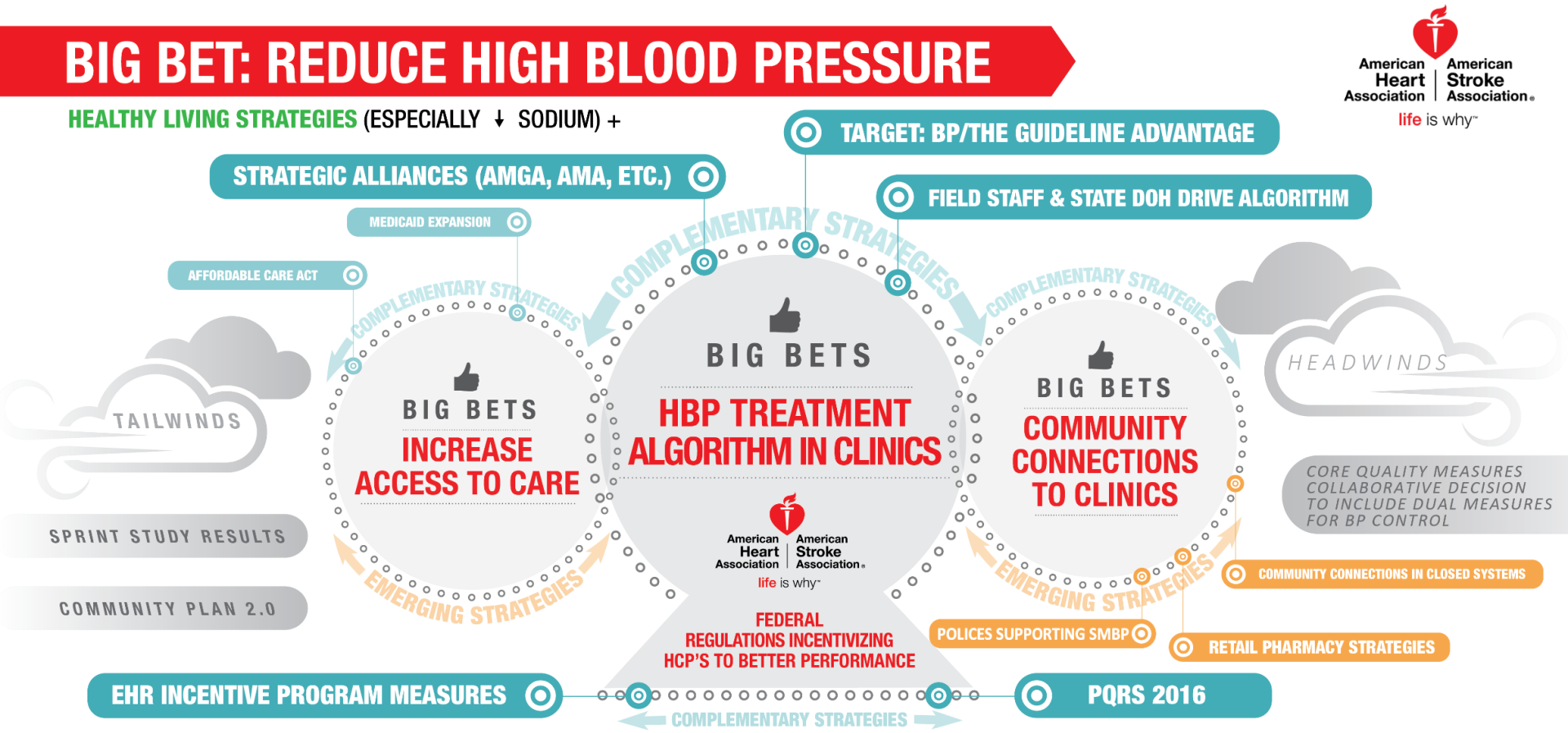
BIG BET: REDUCE HIGH BLOOD PRESSURE



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 11mmgHG and 26 mHG in high risk groups

CHECK IT CHANGE IT
The Durham Blood Pressure Challenge

Check. Change. Control.™

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Why it Works: Key Evidence-Based Scientific Principles

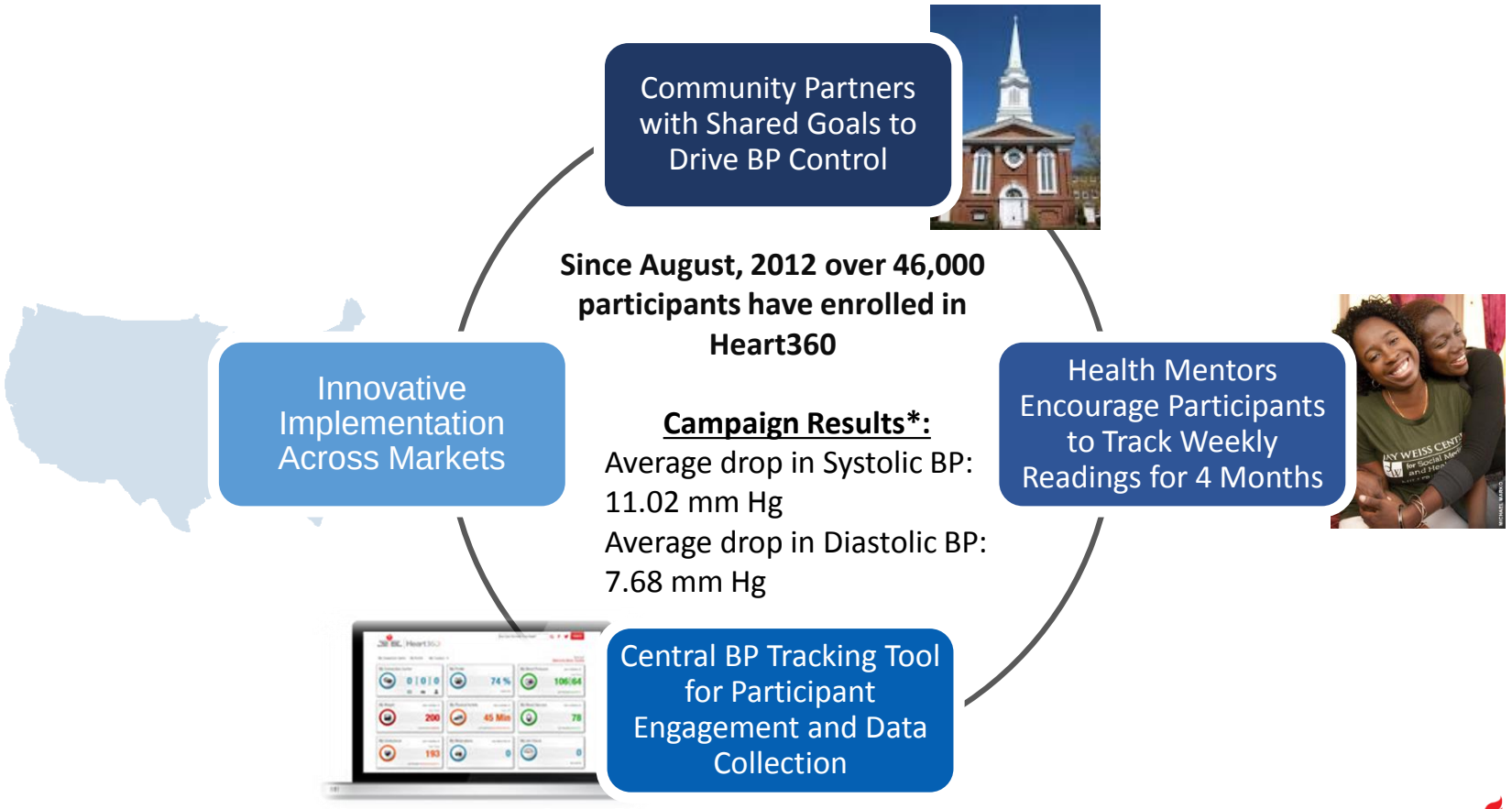
Self Monitoring Makes a Difference
Proven track record for taking blood pressure readings at home or outside of the healthcare provider office setting.

- 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.

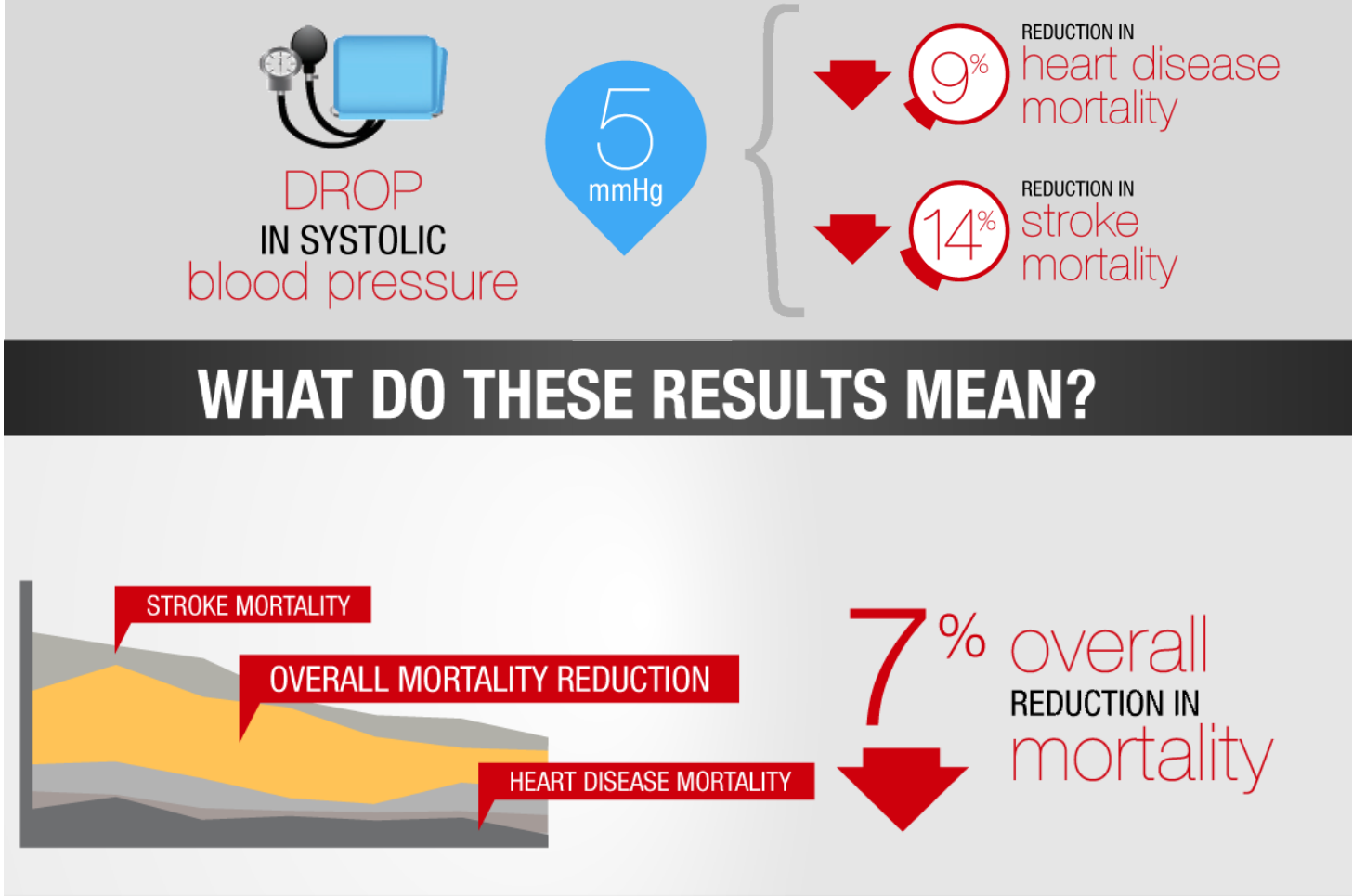
Multicultural Program Investments Make a Difference
Hypertension creates a health disparity for African-Americans.

Program Components



Benefits extend even with partial engagement:

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



American Heart Association®
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AMA
AMERICAN MEDICAL ASSOCIATION

TARGET: BP™

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

American Heart Association | American Stroke Association

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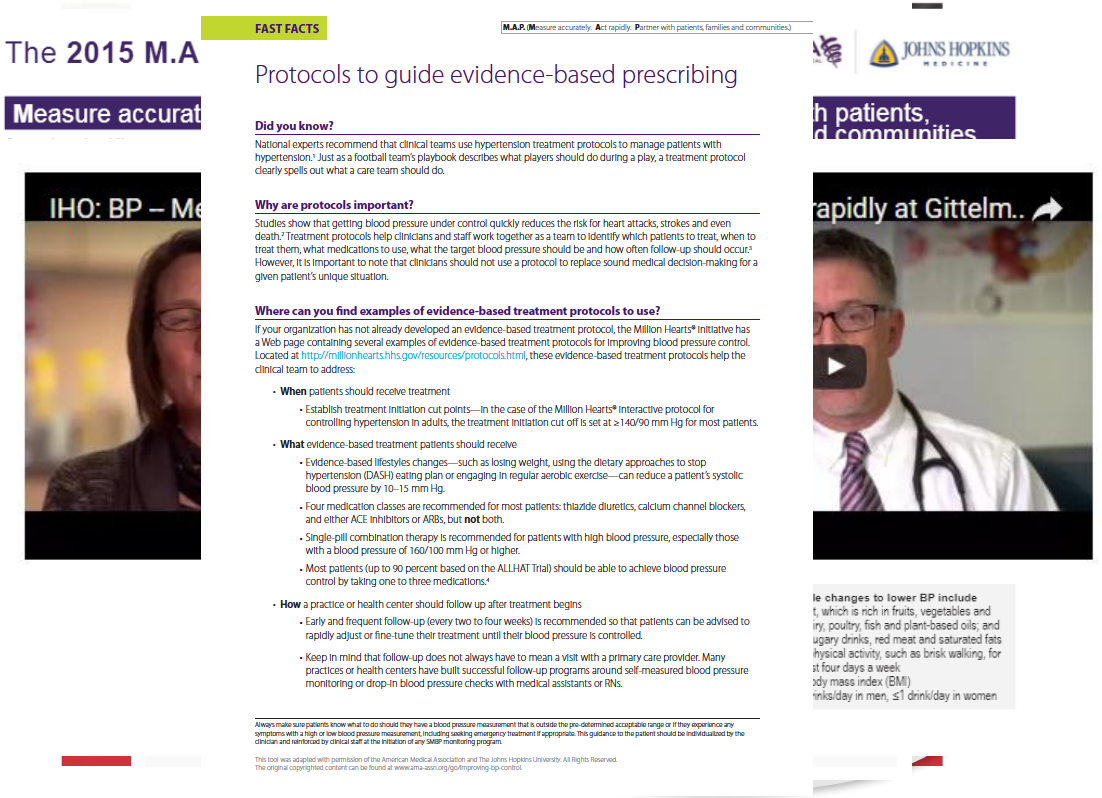
What is Target: BP?

- 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



FAST FACTS

M.A.P. (Measure accurately. Act rapidly. Partner with patients, families and communities)

Protocols to guide evidence-based prescribing

Did you know?

National experts recommend that clinical teams use hypertension treatment protocols to manage patients with hypertension.[1] 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 attacks, strokes and even death.[2] 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.[3] 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 Web page containing several examples of evidence-based treatment protocols for improving blood pressure control. Located at http://millionhearts.hhs.gov/resources/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® interactive protocol for controlling hypertension in adults, the treatment initiation cut off is set at ≥140/90 mm Hg for most patients.
- **What** evidence-based treatment patients should receive
  - Evidence-based lifestyles 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 10–15 mm Hg.
  - Four medication classes are recommended for most patients: thiazide diuretics, calcium channel blockers, and either ACE inhibitors or ARBs, 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 (up to 90 percent based on the ALLHAT Trial) should be able to achieve blood pressure control by taking one to three medications.[4]
- **How** a practice or health center should follow up after treatment begins
  - Early and frequent follow-up (every two to four weeks) is recommended so that patients can be advised to rapidly adjust or fine-tune their treatment until their blood pressure is controlled.
  - Keep in mind that follow-up does not always have to mean a visit with a primary care provider. Many practices or health centers have built successful follow-up programs around self-measured blood pressure monitoring or drop-in blood pressure checks with medical assistants or RNs.

Always make sure patients know what to do should they have a blood pressure measurement that is outside the pre-determined acceptable range or if they experience any symptoms with a high or low blood pressure measurement, including seeking emergency treatment if appropriate. This guidance to the patient should be individualized by the clinician and reinforced by clinical staff at the initiation of any SMBP monitoring program.

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Tools & Resources for Successful Control

American Heart Association | American Stroke Association
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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!