WELCOME

Kate Gainer, PharmD
Executive Vice President and CEO
Iowa Pharmacy Association
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Executive Director
Million Hearts
Iowa Pharmacists and Million Hearts
Improving CV Health Together

Iowa Pharmacy Association
February 15, 2018

Janet Wright MD FACC
Executive Director, Million Hearts
Today’s Objectives

• Kick the tires on Million Hearts 2022
• Discover alignments, new opportunities, and gaps
• Build the foundation for 2018 actions
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 Mortality Rates

County-level percent change in heart disease death rates, 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

Original Million Hearts® Initiative

First 5-year Period

Second 5-year Period

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

Three Models
- CVD Policy Model
- Prevention Impacts Simulation Model (PRISM)
- HealthPartners ModelHealth™: CVD Microsimulation Model
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 aligns with those outlined in Ritchey et al. JAH. 2017;6(5). 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

Priority Populations
Million Hearts® 2022
Priorities

<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

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

<table>
<thead>
<tr>
<th>Goals</th>
<th>Effective Health Care Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improve ABCS</strong>*</td>
<td>High Performers Excel in the Use of...</td>
</tr>
<tr>
<td>Targets: 80%</td>
<td>• Teams—including pharmacists, nurses, community health workers, and cardiac rehab professionals</td>
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<tr>
<td></td>
<td>• Technology—decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care</td>
</tr>
<tr>
<td></td>
<td>• Processes—treatment protocols; daily huddles; ABCS scorecards; proactive outreach; finding those with undiagnosed high BP or cholesterol, tobacco use, PM2.5 exposure</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
</tbody>
</table>

| Increase Use of Cardiac Rehab              |                                                                                                  |
| Target: 70%                                |                                                                                                  |

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

• What stands out?
• Anything surprise you?
• Are you seeing younger folks with CV disease?
The New for 2022

- Physical activity
- Cardiac Rehab
- Engaging Patients in Heart-healthy Behaviors
- Priority Populations
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:
- 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

Inadequate levels of physical activity are associated with $117 billion in annual health care costs.

**MANY AMERICANS DO NOT HAVE SAFE OR CONVENIENT PLACES TO BE ACTIVE**

About 31 million adults aged 50 or older are inactive, meaning they get no physical activity beyond that of daily living.

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.
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
Tips to Help People Be More Active

• 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
Increasing Cardiac Rehabilitation Participation From 20% to 70%: A Road Map From the Million Hearts Cardiac Rehabilitation Collaborative

A. Ades, MD; Steven J. Keteyian, PhD; Janet S. Wright, MD; LaVerne E. Johnson, MD; Nicole A. Floyd, PhD; Anthony F. Hamm, PhD; Karen Lui, RN, MS; Kimberly Newlin, ANP; Donald S. Shepard, PhD; and Randal J. Thomas, MD, MS

The primary aim of the Million Hearts initiative is to prevent 1 million cardiovascular events over 5 years. Concordant with the Million Hearts’ focus on achieving more than 70% performance in the “ABCS” of aspirin for those at high blood pressure control, cholesterol management, and smoking cessation, we outline the cardiovascular events that would be prevented and a road map to achieve more than 70% participation in cardiac rehabilitation (CR)/secondary prevention programs by the year 2022. Cardiac rehabilitation is a class Ia recommendation of the American Heart Association and the American College of Cardiology after myocardial infarction or coronary revascularization, promotes the ABCS along with lifestyle counseling and exercise, and is associated with decreased total mortality, cardiac mortality, and rehospitalizations. However, current participation rates for CR in the United States generally range from only 20% to 30%. This road map focuses on interventions, such as electronic medical record—based prompts and staffing liaisons that increase referrals of appropriate patients to CR, increase enrollment of appropriate individuals into CR, and increase adherence to longer-term CR. We also calculate that increasing CR participation from 20% to 70% would save 25,000 lives and prevent 180,000 hospitalizations annually in the United States.
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
For whom is there strong evidence of benefit---and good insurance coverage---for cardiac rehabilitation?

- 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”
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

- 1-11 sessions (19%)
- 12-24 sessions (23%)
- ≥25 sessions (57%)
- >36 (5%)

>25 sessions (57%)

25-36 sessions (52%)

1-11

12-24

25-36

>36
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
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
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
## 2017 Guidelines
### SMBP Recommendations

### Recommendation for Out-of-Office and Self-Monitoring of BP

References that support the recommendation are summarized in Online Data Supplement 3 and Systematic Review Report.

<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>A&lt;sup&gt;SR&lt;/sup&gt;</td>
<td>1. Out-of-office BP measurements are recommended to <strong>confirm the diagnosis</strong> of hypertension (Table 11) and for <strong>titration of BP-lowering medication</strong>, in conjunction with telehealth counseling or clinical interventions (1-4).</td>
</tr>
</tbody>
</table>

SR indicates systematic review.

### Recommendation for Monitoring Strategies to Improve Control of BP in Patients on Drug Therapy for High BP

References that support the recommendation are summarized in Online Data Supplement 29.

<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>A</td>
<td>1. Follow-up and monitoring after initiation of drug therapy for hypertension control should include systematic strategies to help improve BP, including use of HBPM, team-based care, and telehealth strategies (1-6).</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
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
Discussion #2
Questions? Reactions? Ideas?

• Are you familiar with the local CR programs?
• Could you imagine adding CR participation to your patient counseling content?
• Are there certified/approved PA programs nearby to meet the needs of your patients?
• What other actions constitute “engagement in heart-healthy behavior--and are measureable?”
Tried and True for 2022

- Recognizing stellar performance
- Finding the Undiagnosed
- Ensuring optimal treatment for those diagnosed, based on risk
- Reducing sodium intake
- Decreasing Tobacco prevalence
Million Hearts
Hypertension Control Champions

- 59 Champions over 5 years
- Achieved control at/above 70%
- Serve more than 15 million adults
- Range from small and solo practices to large systems
- 2018 Program announced soon
Precise BP Measurement: Rounding

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

- Last recorded systolic BP – 70,000 patients, age 18–85, with hypertension, in two other medical groups:

Data: AMGA Measure Up Pressure Down
Precise BP Measurement: *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

12/01/12-09/30/13 N=1028
Technique is Critical....and Rare

• Proper patient positioning is important for accuracy both at home and in the office

• Devote eternal vigilance to good technique

Source: Target BP: How to measure your blood pressure at home
Customizable templates and exemplar protocols
- Hypertension control
- Cholesterol management
- Tobacco assessment and treatment

Expands the care team able to assist in achieving control

Standardizes the content and delivery of lifestyle modification advice

Lends clarity, efficiency, and cost-effectiveness to selection of meds

Specifies intervals and processes for follow up
Finding Patients with Undiagnosed Hypertension

- Search EHR data for patients that meet clinical criteria
- Establish clinical criteria for potential undiagnosed HTN
- Implement a plan for addressing the identified population
- Compare to local, state, or national prevalence data

Who is Hiding in Plain Sight?

Thank you

- Please let us know what you are doing to improve cardiovascular health and care
- More information about Million Hearts 2022 at www.millionhearts.gov
- Reach me at janet.wright@cms.hhs.gov
Resources and Additional Slides

Million Hearts®
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
Million Hearts® for Clinicians Microsite

- 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

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
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

Self-Measured BP Resources
‘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
<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Number</th>
<th>Measure Description</th>
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</thead>
<tbody>
<tr>
<td>Aspirin When Appropriate</td>
<td>NQF 0068</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percentage of patients aged 18 years and older with IVD with documented use of aspirin or other antithrombotic</td>
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<tr>
<td>Blood Pressure Control</td>
<td>NQF 0018</td>
<td>Hypertension: Controlling High Blood Pressure</td>
</tr>
<tr>
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<td>% 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>
<tr>
<td>Cholesterol Management</td>
<td>PQRS 438</td>
<td>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease</td>
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<tr>
<td></td>
<td></td>
<td>% who were prescribed or on statin therapy during the measurement period:</td>
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<tr>
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<td></td>
<td>• Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease; OR</td>
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<td></td>
<td>• Adults aged ≥21 years with a fasting or direct LDL-C level ≥ 190 mg/dL; OR</td>
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<td></td>
<td>• Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL</td>
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<tr>
<td>Smoking Cessation</td>
<td>NQF 0028</td>
<td>Preventive Care and Screening: Tobacco Use</td>
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<tr>
<td></td>
<td></td>
<td>% 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</td>
</tr>
<tr>
<td>Cardiac Rehab Referral</td>
<td>NQF 0643</td>
<td>Referral to CR from Inpatient or Outpatient Setting</td>
</tr>
<tr>
<td></td>
<td>NQF 0642</td>
<td>% of patients with an eligible diagnosis who are referred from a hospital (or office) to an early outpatient CR program</td>
</tr>
<tr>
<td>BMI</td>
<td>NQF 0421</td>
<td>Screening and Follow-Up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% 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.</td>
</tr>
</tbody>
</table>
# 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>
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<tbody>
<tr>
<td></td>
<td>Aspirin</td>
<td>Blood Pressure</td>
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<tr>
<td></td>
<td>when Appropriate</td>
<td>Control</td>
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<td>CMS Quality Payment Program</td>
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<td>AHRQ EvidenceNow</td>
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<td>ABFM Prime Registry</td>
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<td>AHA Guideline Advantage</td>
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<td>ACP Genesis Registry</td>
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<tr>
<td>ACC PINNACLE Registry</td>
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<td>CMS ACO Shared Savings</td>
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<td>TCPI</td>
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<td>CMS Home Health CV Data</td>
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<tr>
<td>Registry</td>
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<td>HRSA Uniform Data System</td>
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<td>IHS RPMS</td>
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<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
Cardiac Rehabilitation
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
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 Rehabilitation
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**
Care Utilization Costs by CR Participation in a Universal Health Care System

Costs per day in the 36 mos after referral to cardiac rehab in 4 matched groups. Alter et al., Mayo Clinic Proc. 2017;92:500-511
THANKS FOR ATTENDING!

JOIN US TUESDAY, MARCH 13:

340B

Questions? Contact David Schaaf at dschaaf@iarx.org or 515-270-0713