

## Opportunities for Engagement in Million Hearts™

[Million Hearts™](#) is a national effort to prevent 1 million heart attacks and strokes in five years by aligning public and private initiatives across the United States. Regional, State and local action can help ensure the success of Million Hearts™ by implementing policies and programs at the state and community level that are consistent with Million Hearts™ objective. Regional, State and local partners already make significant contributions to the prevention and control of cardiovascular disease, and this work can be aligned to produce greater impact. Furthermore, many national partners can be engaged at the local level.

### Guiding principles of engagement:

1. Focused attention will drive results.
2. Complete range of aligned programs and policies will have the greatest impact.
3. Public-private partnerships will accelerate spread and achieve scale.

### Opportunities for Engagement

**Increase Focus on ABCS:** *Make clear, through communication, clinical measurement and reporting, to tens of thousands of health care providers and thousands of outpatient health care facilities that improving care of the ABCS is a top priority.*

- Institute and monitor aggregated/standardized quality measures for the **ABCS** – **A**spirin for people at risk, **B**lood pressure control, **C**holesterol management, and **S**moking cessation.

#### Million Hearts™ Clinical Quality Measures

ABCS	Domain	Measures	2012 Physician Quality Reporting System (PQRS)	Medicare and Medicaid EHR Incentive Program	National Quality Forum (NQF)
<b>A</b>	Aspirin Use	<b>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</b> Percentage of patients aged 18 years and older with IVD with documented use of aspirin or other antithrombotic	#204	Stage 1 optional Stage 2 optional	#0068
<b>B</b>	Blood Pressure Screening	<b>Preventive Care and Screening: High Blood Pressure</b> Percentage of patients aged 18 years and older who are screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure readings as indicated	#317	n/a	n/a
	Blood Pressure Control	<b>Hypertension (HTN): Controlling High Blood Pressure</b> Percentage of patients aged 18 through 85 years who had a diagnosis of HTN and whose blood pressure was adequately controlled (<140/90) during the measurement year	#236	Stage 1 optional Stage 2 recommended core	#0018
<b>C</b>	Cholesterol Screening and Control	<b>Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL) Test Performed AND Risk-Stratified Fasting LDL</b> Percentage of patients aged 20 through 79 years whose risk factors have been	#316	Stage 2 optional	TBD

		assessed and a fasting LDL test has been performed AND who had a fasting LDL test performed and whose risk-stratified fasting LDL is at or below the recommended LDL goal			
	Cholesterol Control – Diabetes	<b>Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus</b> Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dL)	#2	Stage 1 optional Stage 2 optional	#0064
	Cholesterol Control – Ischemic Vascular Disease	<b>Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control</b> Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and who had most recent LDL-C level in control (less than 100 mg/dL)	#241	Stage 1 optional Stage 2 optional	#0075
S	Smoking Cessation	<b>Preventive Care and Screening: Tobacco Use</b> Percentage of patients aged 18 years and older who were screened about tobacco use one or more times within 24 months and who received cessation counseling intervention if identified as a tobacco user	#226	Stage 1 optional Stage 2 recommended core	#0028

\* May be revised based on the upcoming release of ATP IV clinical guidelines

^ Part of an all-or-nothing diabetes measure set

MU = [Meaningful Use](#), PQRS = [Physician Quality Reporting System](#), NQF = [National Quality Forum](#), ACO = [Accountable Care Organization](#)

Note: Centers for Medicare and Medicaid Services PQRS e-specifications entitled “2012 EHR Documents for Eligible Professionals July 2011” can be found under “Downloads” at: [www.cms.gov/PQRS/20\\_AlternativeReportingMechanisms.asp](http://www.cms.gov/PQRS/20_AlternativeReportingMechanisms.asp)

*Some Potential Partners: Public health professionals and private healthcare providers, Quality Improvement Organizations, Regional Extension Centers, Health Information Technology Vendors, Community Transformation Grantees, Patient advocacy groups.*

**Foster Clinical Innovations:** Increase use of effective ABCS care practices through innovations such as team-based care, patient-centered medical homes, and interventions to promote adherence to treatment.

- Partner with the [Medicare Quality Improvement Organizations](#) (QIOs) on 10th Statement of Work initiatives that promote quality initiatives to improve the ABCS.
- Support team-based care that improves care coordination by utilizing nurses, nurse practitioners, physician assistants, [pharmacists](#), dietitians, and community health workers to promote medication adherence and patient navigation to free and low-cost drug programs.

- Support primary care system redesign efforts that improve access to care through team-based delivery, open scheduling, expanded hours, transportation assistance, and asynchronous contact (e.g., phone visits, secure email access, online patient portals).
- Ensure that patient education and self-management are delivered in a culturally and linguistically appropriate manner through patient educators, navigators, coaches, and linkages to community resources.
- Promote payment reform initiatives that incentivize improvements in ABCS clinical quality measures through new models of care (e.g. value-based purchasing, [bundled payments](#), [Accountable Care Organizations](#) (ACOs), and [medical/health homes](#)).
- Review professional practice rules and collaborate with partners to allow professionals to practice at the full extent of their licenses and to be reimbursed for services rendered (e.g. medication management therapy).
- Collaborate with Federally Qualified Health Centers and other entities in efforts to develop and test new models of care (medical homes and Accountable Care Organizations).

*Some Potential Partners:* State Medicaid Programs, Regional, State and local public health agencies and organizations, State chapters of Medical professional organizations, Pharmacy and pharmacist organizations, Primary Care Associations, Federally Qualified Health Centers, Schools of medicine, nursing and pharmacy, [Medicare Quality Improvement Organizations](#), Health plans, Health systems, [Community Transformation Grant](#) recipients, foundations, academic institutions, and many more.

***Enhance Health Information Technology (HIT):*** Empower health care providers and systems to improve cardiovascular care through EHRs, registries and point of care improvement.

- Encourage measurement and reporting of clinical quality measures for the ABCS in electronic health records by working with health information exchanges, [Beacon Communities](#), and [Regional Extension Centers](#) (RECs). (<http://healthit.hhs.gov>).
- Educate HIT community on ABCS-related clinical guidelines to drive their incorporation into EHR clinical decision supports.
- Promote meaningful use of HIT to improve cardiovascular risk factors (registry functionality within EHRs, provider and system level feedback reports, patient recall, provider reminders, tracking of patient referrals).

*Some Potential Partners:* Private companies and business coalitions, Health information technology groups, Health Plans, Health Systems, Medicare QIOs, Medical Professional Associations, Public health chronic disease programs.

***Expand Community Initiatives to Support Healthier Behaviors:*** Improve access, outreach, and public communication related to the ABCS through policies that achieve synergy between prevention in health care and prevention in the community.

- Promote smoke-free air, quit lines, and other tobacco prevention policies.
- Support policies for reducing sodium and eliminating trans-fats in food (e.g., menu-labeling requirements in chain restaurants, procurement policies).
- Promote heart health through public and private workplace wellness programs.

05/18/12

- Work through state affiliates to include recommended ABCS prevention and treatment in state employee insurance benefits and insurance exchanges.  
<http://www.businessgrouphealth.org/benefitstopics/topics/purchasers/fullguide.pdf>  
<http://www.cdc.gov/workplacehealthpromotion/>
- Extend care beyond the clinic using traditional and non-traditional (e.g., [community health worker](#)) providers trained to counsel patients to improve the ABCS.
- Support the work of [Community Transformation Grants](#) (CTGs).

*Some Potential Partners:* Patient advocacy organizations, Consumer groups with a health focus, Private companies and business coalitions, Health information technology groups, Community-based organizations, public health chronic disease programs, academic institutions.

### **Identify and Share Success**

Rapid evaluation and sharing of successful strategies that improve health and reduce heart attacks and strokes is critical. Million Hearts™ success stories will soon be available at: <http://millionhearts.hhs.gov>. Through this website, states and partners are encouraged to submit and share their own successes.