

Million Hearts: A Call to Action



Ashby Wolfe, MD, MPP, MPH
Chief Medical Officer, Region IX
Centers for Medicare and Medicaid Services

Changing the Menu: Strategies for Healthy Eating
and Sodium Reduction in California
September 30, 2015
Sacramento, CA

Disclaimer

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

Objectives

- Provide an overview of the Million Hearts Initiative
- Review resources to achieve the goals of Million Hearts
 - Roles of professionals & lay health workers in outpatient settings
 - Systems and workflow protocols focusing on key patient groups
- Discuss measurement and public health applications
 - Health Information Technology (HIT) tools
 - Community approaches
 - New models to incentivize population health management

Better know an audience...

- CDPH + AHA Stakeholders
 - Evidence-based team approach
 - Collaboration & communication



- GOAL: Prevent & optimally manage chronic disease
 - Evidence-based programs to promote healthy behaviors
 - Improve prevention, diagnosis and management of chronic disease
 - Emphasis on healthy communities

Better. Smarter. *Healthier.*

So we will continue to work across sectors and across the aisle for the goals we share: *better care, smarter spending, and healthier people.*

Historical state

Evolving future state

Public and Private sectors

Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Systems and Policies

- Fee-For-Service Payment Systems



Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

How do we get there?

- Partnership for Patients
- New Models of Care & Payment to Support Medicare-Medicaid Enrollees
 - Accountable Care Organizations (ACOs)
 - Bundled Payments for Care Improvement
 - Comprehensive Primary Care Initiative & Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Health Care Innovation Challenge & Innovation Center Grants
- The Million Hearts Challenge
- Value Based Purchasing

Million Hearts®

**Goal: Prevent 1 million heart attacks
and strokes by 2017**

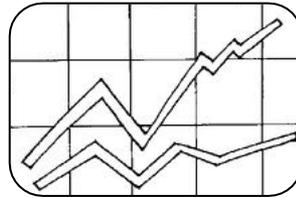
- National initiative co-led by CDC and CMS
- In partnership with federal, state, and private organizations innovating and implementing
- To address the causes of 1.5M events and 800K deaths a year, \$312.6 B in annual health care costs and lost productivity and major disparities in outcomes



Key Components of Million Hearts®

Excelling in the ABCS
Optimizing care

Prioritizing
the ABCS



Health tools
and technology



Innovations in
care delivery



Keeping Us Healthy
Changing the context



Health Disparities

Million Hearts® at 30 Months

66,780

likes on Facebook



45,787

subscribers to the Million Hearts® e-Update



40M+

reached with hypertension protocol tools



96

public- and private-sector partners



1M+ visits to the Million Hearts® website



What Will It Take to Prevent a Million?

- 6.3 million smokers need to quit
- 10 million need to achieve consistent blood pressure control
- Reduce the intake of salt by 20% each day



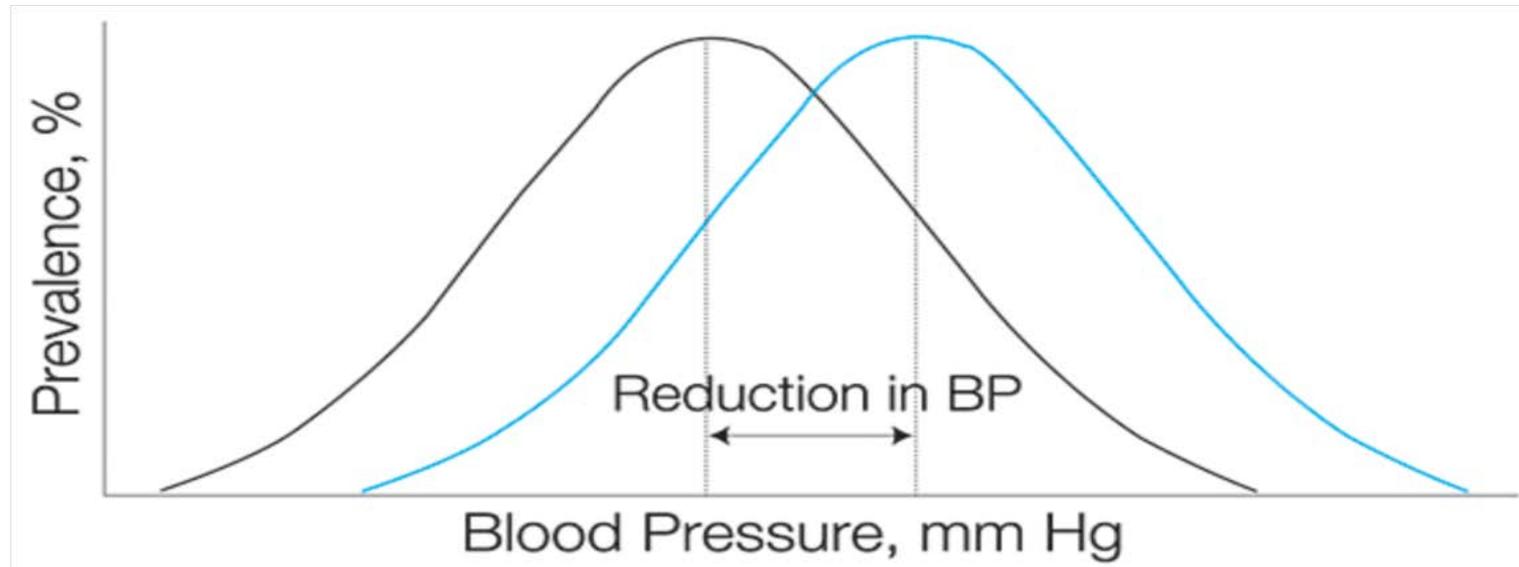
- Knowledge Translation and Diffusion
- Create Incentives and Alignment
- Stakeholders in Action
- Measuring and Reporting Systematically
- Innovating and Implementing for Population Health
- Research: Understanding What Works and Why

Getting to a Million

Intervention	2009-2010 Measure Value	2017 Target	Clinical target
A spirin for those at risk	54%	65%	70%
B lood pressure control	53%	65%	70%
C holesterol management	32%	65%	70%
S moking cessation	22%	65%	70%
Smoking prevalence	21%	19%	
Sodium reduction	~ 3.5 g/day	20% reduction	
Trans fat reduction	~ 1% of calories	50% reduction	

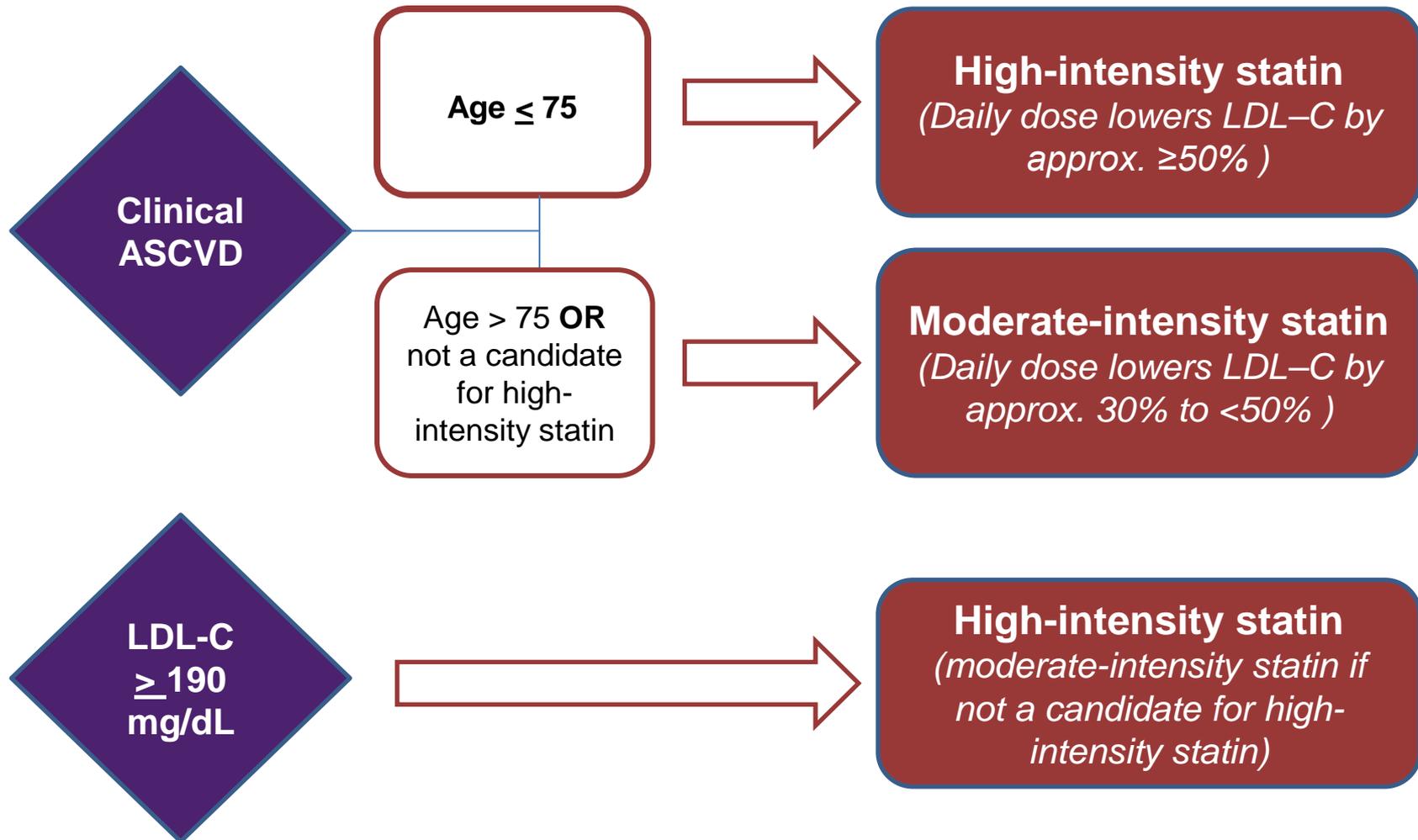
It Doesn't Take Much to Have a BIG Impact

Small Reductions in Systolic BP Can Save Many Lives

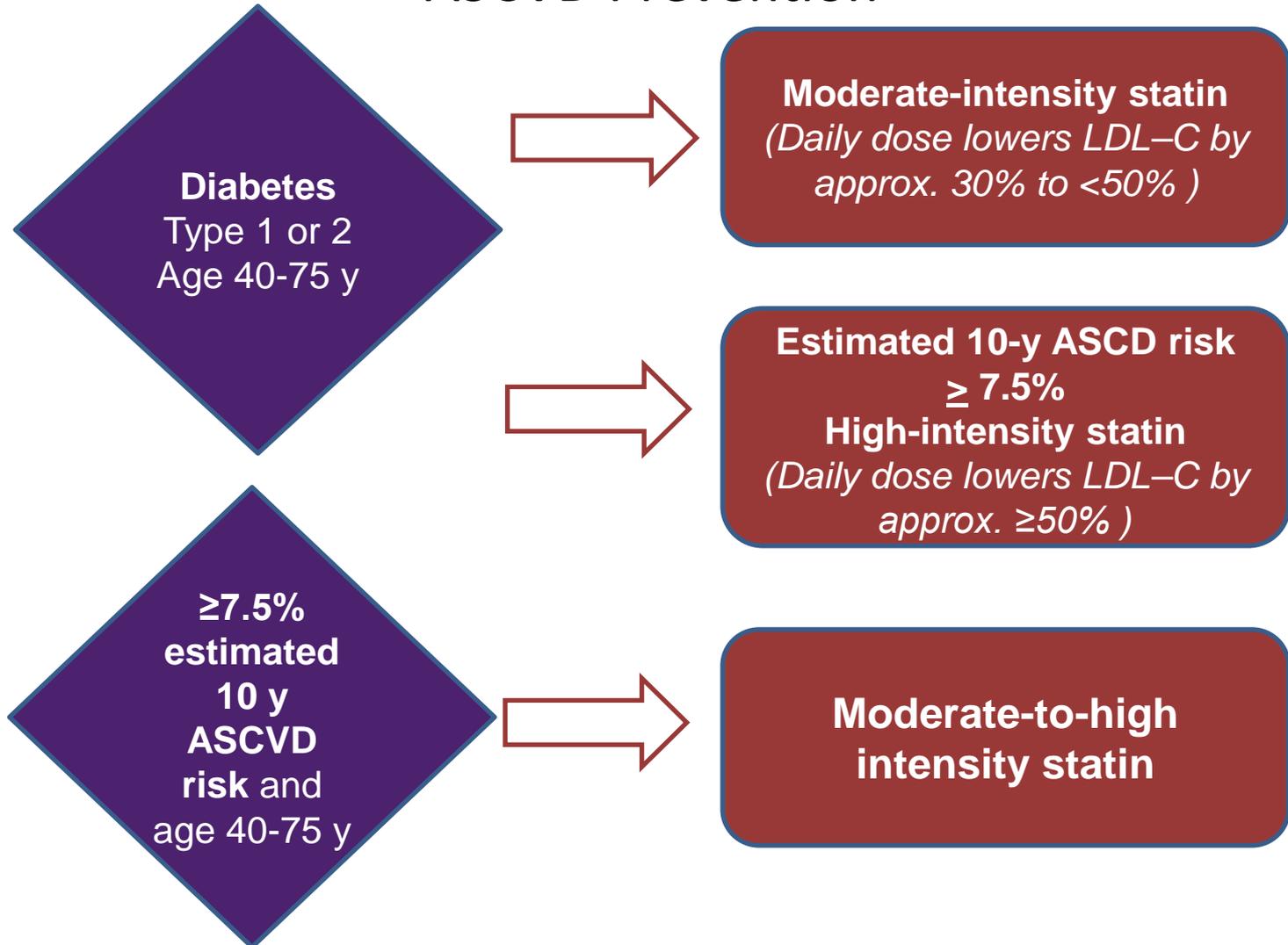


Reduction in BP, mm Hg	% Reduction in Mortality		
	Stroke	CHD	Total
2	-6	-4	-3
3	-8	-5	-4
5	-14	-9	-7

Recommendations for Statin Therapy in ASCVD Prevention



Recommendations for Statin Therapy in ASCVD Prevention



Comparison of Treatment Goals

	JNC 7	2014 Hypertension Guidelines
Adults (<60 years)	<140 / 90 mmHg	<140 / 90 mmHg
Adults (≥60 years)	<140 / 90 mmHg	<150 / 90 mmHg
Diabetes / Chronic Kidney Disease	<130 / 90 mmHg	<140 / 90 mmHg

- Current national performance measures use <140/90
- Some guidelines and reports include a treatment goal of <150/90 mmHg for those ≥80 years of age

Protocol as the Team Playbook

The red, italicized text may be modified by the user to provide specific drug names.

Reset Form

Name of Practice

Protocol for Controlling Hypertension in Adults¹

The blood pressure tolerance modification damage and review hyperten

Opinion

VIEWPOINT Protocol-Based Treatment of Hypertension
A Critical Step on the Pathway to Progress

ment, and patient other BP goals. Lifestyle assessed for target organ t their care and requesting l control. For patients with box on the right below.

Systolic (Stage
• L
• C

Thomas R. Frieden, MD, MPH
Centers for Disease Control and Prevention, Atlanta, Georgia.

Sallyann M. Coleman King, MD, MSc
Centers for Disease Control and Prevention, Atlanta, Georgia.

Janet S. Wright, MD
Centers for Disease Control and Prevention, Atlanta, Georgia.

Re-check review within

stakeholder in

Elements Associated with Effective Implementation and Use of a Protocol
Insights from Key Stakeholders

Simple, evidence-based treatment protocols are an essential tool for improving blood pressure control among practices and health care systems. To accelerate implementation of protocols, Million Hearts[®] convened a group of stakeholders that the use of protocols is key to their success in blood pressure control. This document is a compilation of comments from the stakeholder discussions in fall 2012 about adoption and use of protocols within their system.



consider for hypertension and other conditions
artery disease/Post

ACCEPTED MANUSCRIPT

Go AS, et al
High Blood Pressure Control

AHA/ACC/CDC Science Advisory

An Effective Approach to High Blood Pressure Control

A Science Advisory From the American Heart Association, the American College of Cardiology, and the Centers for Disease Control and Prevention

Clinical Example



Spotlight:

Comprehensive Primary Care, SAMA Healthcare

SAMA Healthcare Services is an independent four-physician family practice located in El Dorado, a town in rural southeast Arkansas

Services made possible by CPC investment

- Care management
 - Each **Care Team** consists of a doctor, a nurse practitioner, a care coordinator, and three nurses
 - Teams drive **proactive preventive care** for approximately 19,000 patients
 - Teams use Allscripts' **Clinical Decision Support** feature to alert the team to missing screenings and lab work
- Risk stratification
 - The practice implemented the **AAFP six-level risk stratification tool**
 - Nurses mark records **before the visit** and physicians **confirm stratification during the patient encounter**



Team-Based Care and Improved Blood Pressure Control

A Community Guide Systematic Review

Krista K. Proia, MPH, Anilkrishna B. Thota, MBBS, MPH, Gibril J. Njie, MPH, Ramona K.C. Finnie, DrPH, David P. Hopkins, MD, MPH, Qaiser Mukhtar, PhD, Nicolaas P. Pronk, PhD, MA, Donald Zeigler, PhD, Thomas E. Kottke, MD, Kimberly J. Rask, MD, PhD, Daniel T. Lackland, DrPH, Joy F. Brooks, MHA, Lynne T. Braun, PhD, CNP, FAHA, Tonya Cooksey, MS, RD, and the Community Preventive Services Task Force

Context: Uncontrolled hypertension remains a widely prevalent cardiovascular risk factor in the U.S. team-based care, established by adding new staff or changing the roles of existing staff such as nurses and pharmacists to work with a primary care provider and the patient. Team-based care has the potential to improve the quality of hypertension management. The goal of this Community Guide systematic review was to examine the effectiveness of team-based care in improving blood pressure (BP) outcomes.

Evidence acquisition: An existing systematic review (search period, January 1980–July 2003) assessing team-based care for BP control was supplemented with a Community Guide update (January 2003–May 2012). For the Community Guide update, two reviewers independently abstracted data and assessed quality of eligible studies.

Evidence synthesis: Twenty-eight studies in the prior review (1980–2003) and an additional 52 studies from the Community Guide update (2003–2012) qualified for inclusion. Results from both bodies of evidence suggest that team-based care is effective in improving BP outcomes. From the update, the proportion of patients with controlled BP improved (median increase=12 percentage points); systolic BP decreased (median reduction=5.4 mmHg); and diastolic BP also decreased (median reduction=1.8 mmHg).

Conclusions: Team-based care increased the proportion of people with controlled BP and reduced both systolic and diastolic BP, especially when pharmacists and nurses were part of the team. Findings are applicable to a range of U.S. settings and population groups. Implementation of this multidisciplinary approach will require health system-level organizational changes and could be an important element of the medical home.

(Am J Prev Med 2014;47(1):86–99) © Published by Elsevier Inc. on behalf of American Journal of Preventive Medicine

From the Community Guide Branch (Proia, Thota, Njie, Finnie, Hopkins, Mukhtar, Cooksey), Division of Epidemiology, Analysis, and Library Services, Center for Surveillance, Epidemiology, and Laboratory Services, CDC, Emory University, Georgia Medical Care Foundation (Rask), Atlanta, Georgia; HealthPartners (Pronk, Kottke), Minneapolis, Minnesota; American Medical Association (Zeigler); Rush College of Nursing (Braun), Chicago, Illinois; South Carolina Department of Health & Environmental Control (Brooks), Columbia; and Medical University of South Carolina (Lackland), Charleston, South Carolina

Names and affiliations of the Community Preventive Services Task Force members can be found at www.thecommunityguide.org/about/task-force-members.html.

Address correspondence to: Anilkrishna B. Thota, MBBS, MPH, Community Guide Branch, CDC, 1600 Clifton Road, Mailstop E69, Atlanta, GA 30333. E-mail: athota@cdc.gov.
0749-3797/\$36.00

<http://dx.doi.org/10.1016/j.amepre.2014.03.004>

86 Am J Prev Med 2014;47(1):86–99

Published by Elsevier Inc. on behalf of American Journal of Preventive Medicine

Context

Hypertension, defined as having systolic blood pressure (SBP) \geq 140 mmHg or diastolic blood pressure (DBP) \geq 90 mmHg at two or more office visits or current use of BP-lowering medications,^{1,2} remains the predominant risk factor for cardiovascular mortality in the U.S.^{3,4} The prevalence of hypertension among U.S. adults (aged \geq 18 years) from 2003 to 2010 was 30.4%—approximately 66.9 million adults.⁵ Estimated annual costs of hypertension are \$93.5 billion per year¹ and are projected to increase to \$130.4 billion in 2030 if the status quo is maintained.⁶ Because 90% of adults with uncontrolled hypertension have a usual

- Team-based care increased the proportion of people with controlled blood pressure
- Team-based care reduced both systolic and diastolic blood pressure
- Effect magnified when pharmacists and nurses were part of the team
- Applicable to a wide range of population groups and geographic settings
- Implementation requires system-level organizational changes, such as adoption of the medical home model

Proia, *et al.* 2014. Team Based Care and Improved Blood Pressure Control: A Community Guide Systematic Review. Am J Prev Med 47(1):86-99.

Variable	Proportion of patients with BP controlled		Reduction in SBP		Reduction in DBP	
	Number of studies	Median estimate ^a (pct pts)	Number of studies	Median estimate (mmHg)	Number of studies	Median estimate (mmHg)
Community-based ^b	5	12.0	7	4.5	6	0.5
Type of team member added						
Nurse	16	8.5	22	5.4	18	2.9
Pharmacist	11	22.0	13	5.0	13	1.7
Nurse + Pharmacist	4	16.2	5	5.6	3	3.5
Other	2	2.6	4	3.2	4	0.4
Type of team member role related to medication						
Independent ^{c,d}	9	17.4	12	7.2	10	3.5
PCP approval ^e	11	15.0	11	5.0	9	1.7
Support only ^{d,f}	12	7.9	20	3.8	18	1.0
Number of team members added^g						
PCP + 1 team member ^h	20	10.5	25	5.6	24	1.4
PCP + 2 team members ^h	6	13.5	8	5.3	7	3.2
PCP + 3 or more team members	5	17.0	8	5.9	5	3.0
Baseline level of percentage with controlled BP						
0	14	14.0	NA	NA	NA	NA
≤ 50	14	14.0	NA	NA	NA	NA
> 50	5	1.1	NA	NA	NA	NA
Baseline SBP (mmHg)						
≥ 140	NA	NA	26	5.9	NA	NA
< 140	NA	NA	16	5.0	NA	NA
Baseline DBP (mmHg)						
≥ 90	NA	NA	NA	NA	6	3.3
< 90	NA	NA	NA	NA	30	1.6

Variable	Change in mean	Change in proportion of patients at goal
Lipid outcome		
Total cholesterol	-6.3 mg/dL (6 studies) ^{21,34,38,49,50,56}	13.0 pct pts (3 studies) ^{41,57,75}
LDL cholesterol	-4.3 mg/dL (11 studies) ^{21,23,25,34,36,38,45,47,50,63,90,96}	3.2 pct pts (5 studies) ^{23,43,75,95,96}
HDL cholesterol	1.3 mg/dL (6 studies) ^{21,23,34,38,49,50}	-6.0 pct pts (1 study) ⁴¹
Triglycerides	-7.9 mg/dL (5 studies) ^{21,23,34,38,50}	No studies
Diabetes outcome		
A1C level	-0.3% (11 studies) ^{21,25,33,36,45,49,50,63,72,74,96}	10.0 pct pts (6 studies) ^{33,41,43,75,96}
Blood glucose	-7.0 mg/dL (5 studies) ^{23,34,38,44,50}	NA

HDL, low-density lipoprotein; LDL, low-density lipoprotein; NA, not applicable; pct pts, percentage points

Proia et al / Am J Prev Med 2014;47(1):86-99



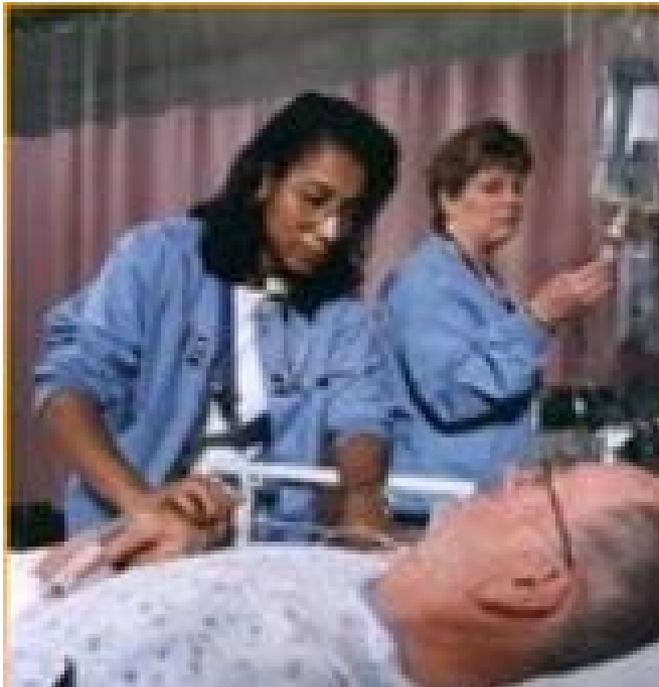
Team Members

- Identify roles of each professional
 - MD or DO
 - NP or PA
 - Pharmacist
 - Nutritionist/Dietician
 - Care manager
 - Promotoras or other community experts
- **Key question** → Is it necessary to have everyone involved at all times?
- **Don't forget** → Patient & their family



“What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?”

Either your health is a priority now....

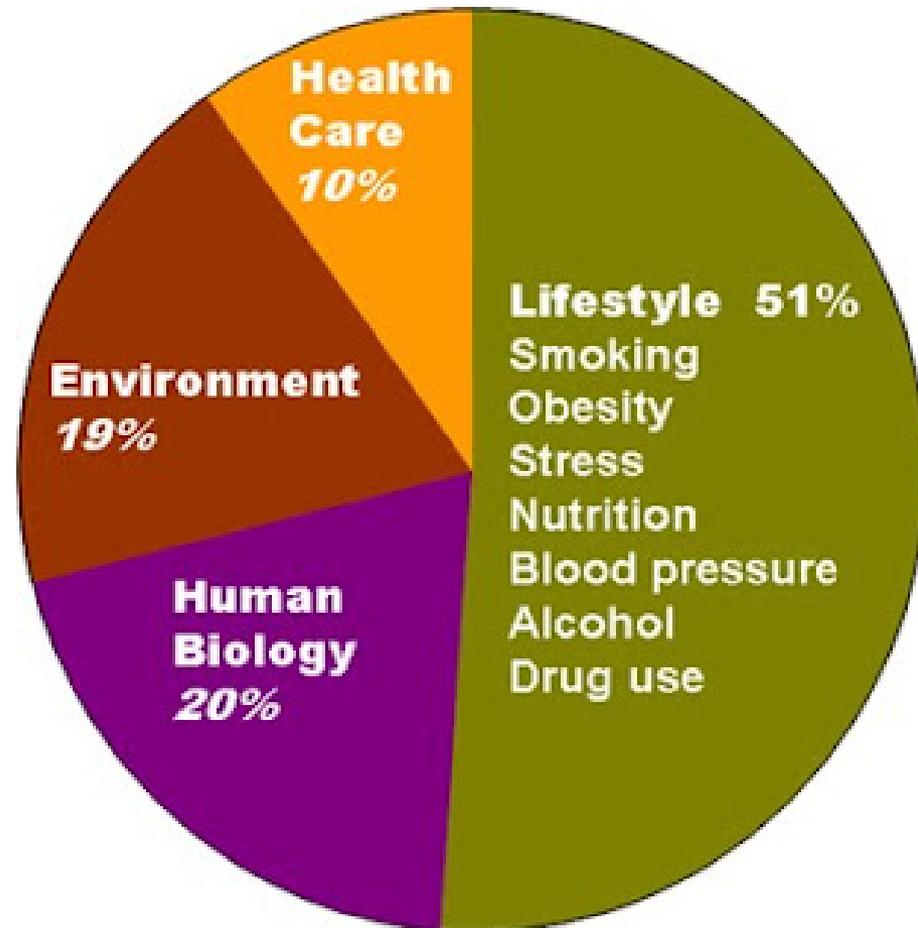


....Or it is a priority later



What happens outside the office?

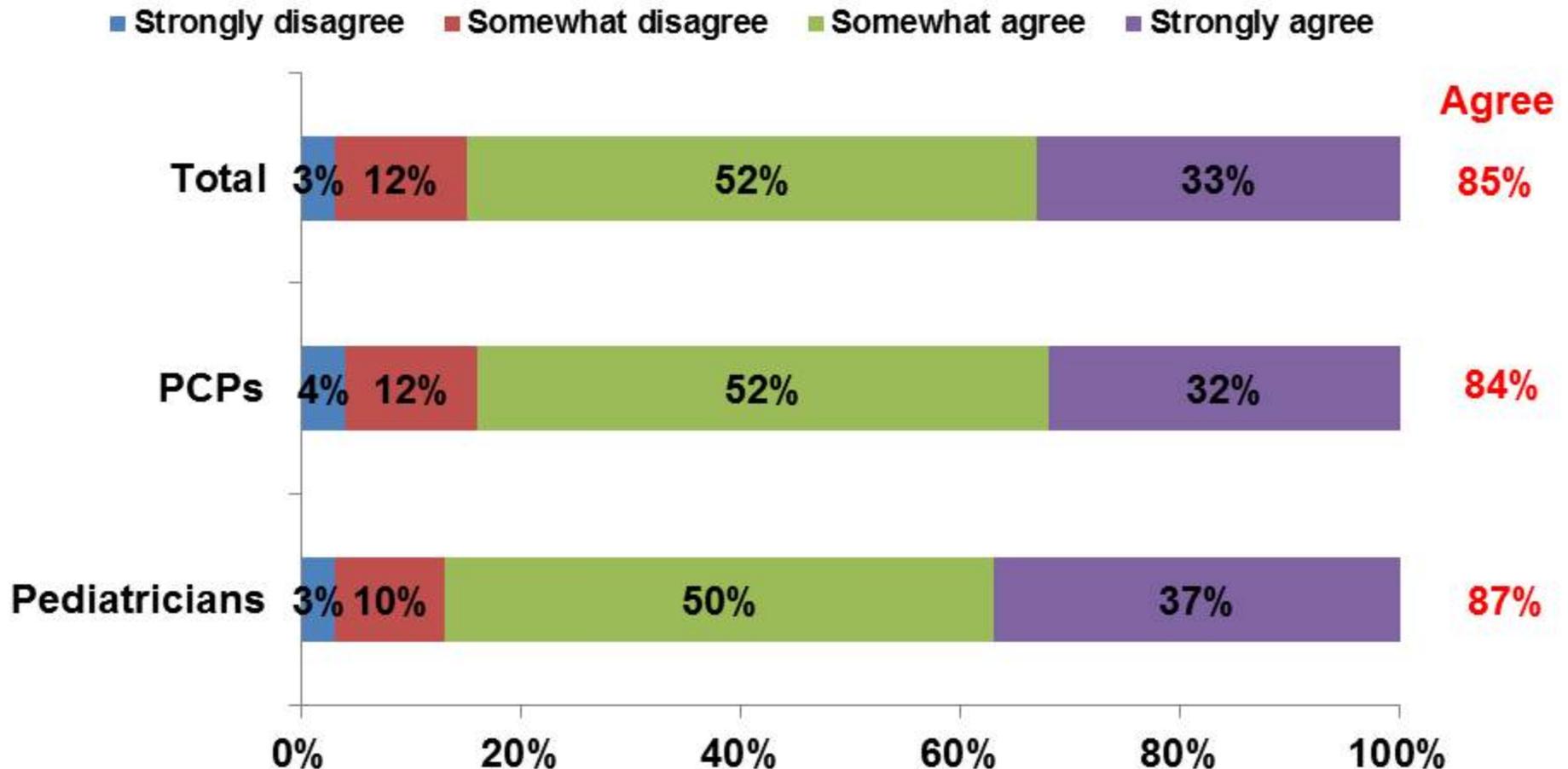
- Link clinics with community resources
 - Referral networks
 - Use of HIT
- Promotores
- Specialist physicians
- Community events
 - Blood pressure screenings
 - Health fairs
 - Marketplace or Medicaid enrollment activities



Adapted from: McGinnis JM, William-Russo P, Knickerman JR. The case for more active policy attention to health promotion. Health Aff (Millwood)2002;21(2):78-93

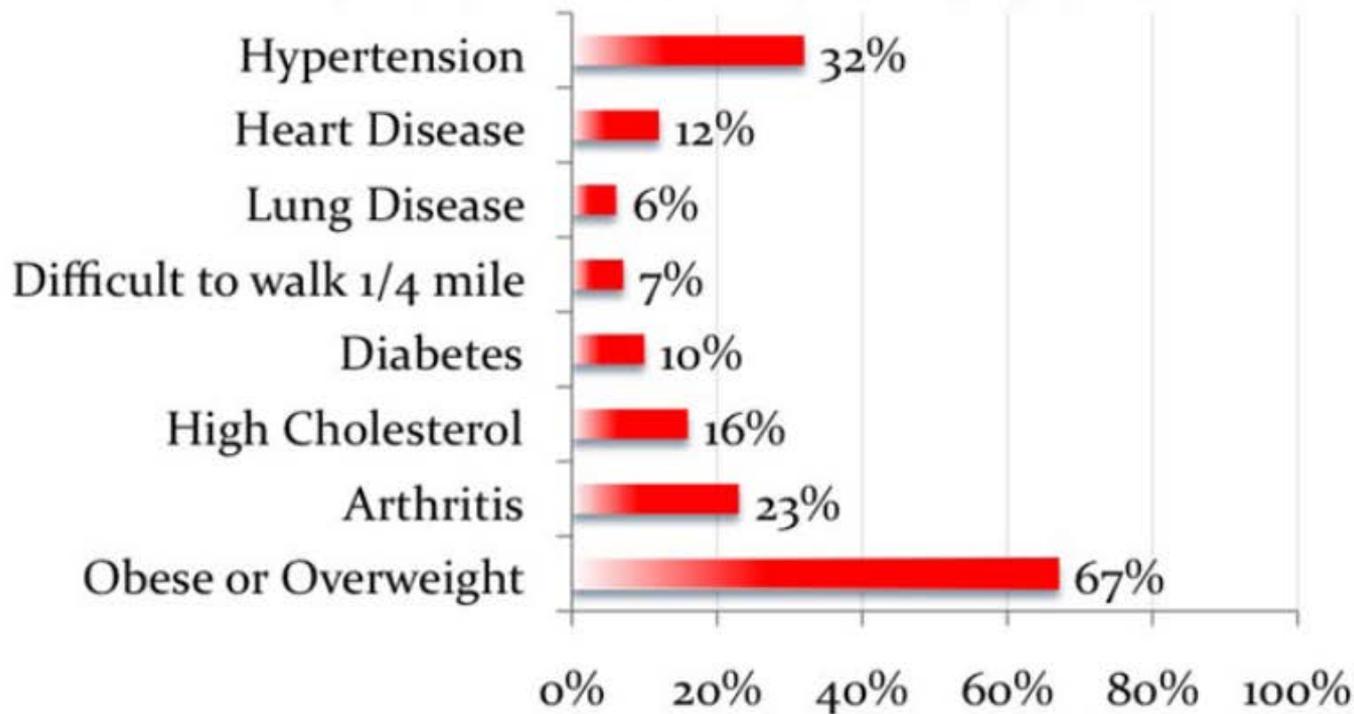
Social Determinants of Health:

Most physicians believe addressing patients' social needs is as important as dealing with medical conditions



Source: 2011 Physicians' Daily Life Report, Robert Wood Johnson Foundation and Harris Interactive, November 15, 2011

Lifestyle Diseases



Percentage of U.S. adults with the following lifestyle diseases and conditions

Leveraging the Community

- Community health workers & Promotores <http://www.cachw.org/>
- ACA allowed CMS to update Medicaid funding rule for preventive services 2013

Examples of CHW/Promotor/a Work:

- Provide referral services
- Work with a family to develop an economical and nutritious meal plan
- Facilitate diabetes educational groups, aimed at better self-care
- Visit crop fields to educate migrant farmers on HIV prevention
- Consult on family planning or pre/postnatal care
- Translate a medical document for a patient
- Go door-to-door to locate isolated elders to conduct health assessments and referrals



Opportunities for Physical Activity

- Controls weight
- Reduces risk of chronic health conditions
- Improves mood
- Boosts energy
- Promotes better sleep & reduces fatigue
- Reduces inflammation

Goal:

20 – 30 minutes of physical activity every day

Moderate Physical Activity	Approximate Calories/30 Minutes for a 154 lb Person¹	Approximate Calories/Hr for a 154 lb Person¹
Hiking	185	370
Light gardening/yard work	165	330
Dancing	165	330
Golf (walking and carrying clubs)	165	330
Bicycling (<10 mph)	145	290
Walking (3.5 mph)	140	280
Weight lifting (general light workout)	110	220
Stretching	90	180
Vigorous Physical Activity	Approximate Calories/30 Minutes for a 154 lb Person¹	Approximate Calories/Hr for a 154 lb Person¹
Running/jogging (5 mph)	295	590
Bicycling (>10 mph)	295	590
Swimming (slow freestyle laps)	255	510
Aerobics	240	480
Walking (4.5 mph)	230	460
Heavy yard work (chopping wood)	220	440
Weight lifting (vigorous effort)	220	440
Basketball (vigorous)	220	440

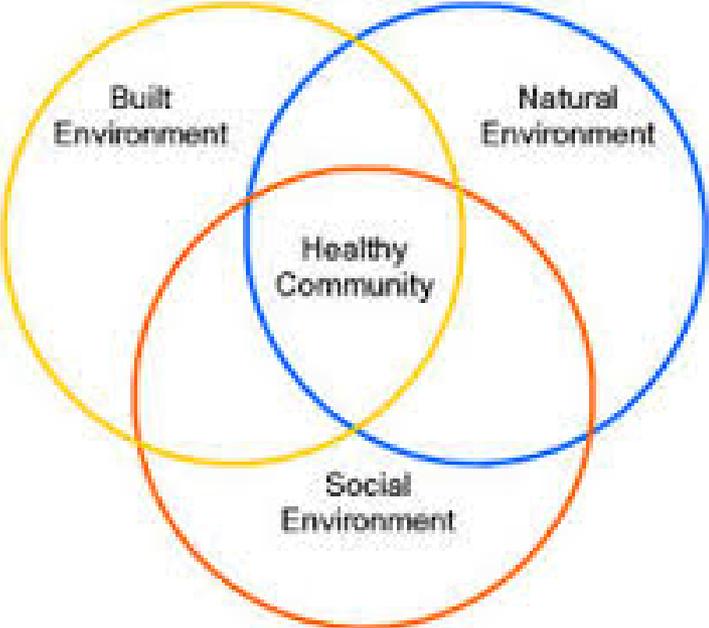
¹ Calories burned per hour will be higher for persons who weigh more than 154 lbs (70 kg) and lower for persons who weigh less.

Source: Adapted from [Dietary Guidelines for Americans 2005, page 16, Table 4](#).

The Built Environment



Effective design increases opportunities for healthy behaviors



Healthy Meal Choices

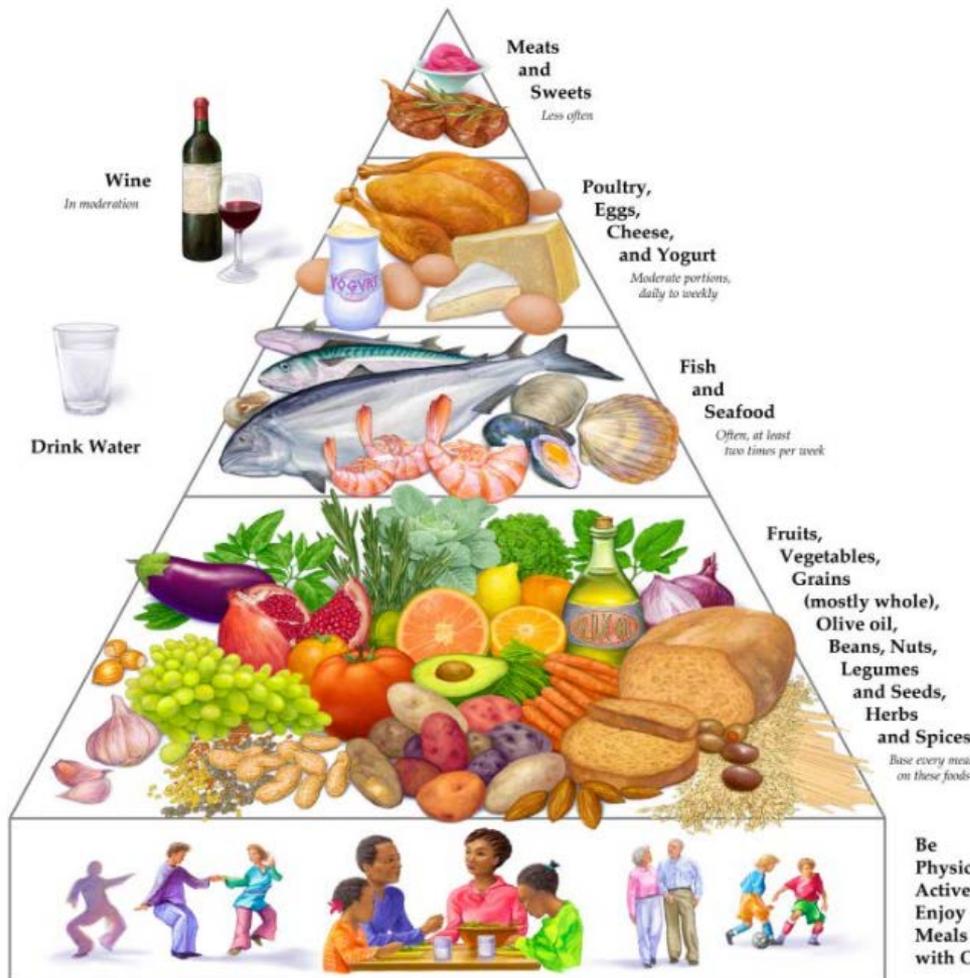


Illustration by George Middleton

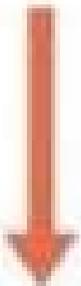
© 2009 Oldways Preservation and Exchange Trust

www.oldwayspt.org



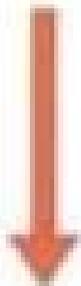
Healthy Swaps

CANDY



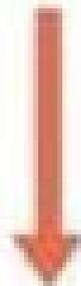
FRUIT

SALT

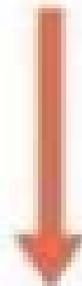


HERBS

BUTTER



AVOCADO



MILK



44% of U.S. Sodium Intake Comes from 10 Types of Foods

Rank	Food Types	%
1	Bread and rolls	7.4
2	Cold cuts and cured meats	5.1
3	Pizza	4.9
4	Poultry	4.5
5	Soups	4.3
6	Sandwiches	4.0
7	Cheese	3.8
8	Pasta mixed dishes	3.3
9	Meat mixed dishes	3.2
10	Savory snacks	3.1

Keeping Us Healthy

Changing the Context: trans fat

Eliminating *trans* fat in the American diet could prevent 20,000 heart attacks, 7,000 deaths—every year

Citing new scientific evidence and findings from expert scientific panels, FDA takes first step to eliminate trans fat from processed foods





Self-Measured Blood Pressure Monitoring



Cardiovascular Health

ACTION STEPS for Employers

Cardiovascular disease (CVD) accounts for one of three deaths in the United States each year. Strategies that address

Translate and Diffuse Knowledge



Help prevent **1 million** heart attacks and strokes by 2017.

e-update

American Heart Month 2013

Tools You Can Use

- **Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners**—This new guide focuses on integrating self-measured blood pressure monitoring into chronic disease prevention efforts.
- **Million Hearts™ en español**—Visit our newly translated website, chock full of information and resources for Spanish speakers.
- **More materials in Spanish**—Several new resources provide strategies and tips to help consumers understand and manage their risk factors for heart disease



Welcome to a special American

Centers for Disease Control and Prevention

MMWR

Morbidity and Mortality Weekly Report

Early Release / Vol. 62

September 3, 2013

Vital Signs: Avoidable Deaths from Heart Disease, Stroke, and Hypertensive Disease — United States, 2001–2010

Abstract

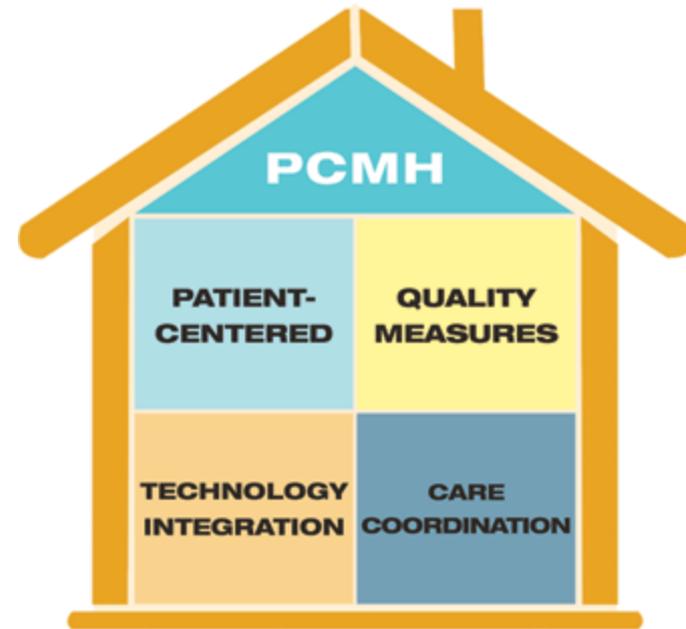
Preventive health care or timely and effective medical care can be considered... of death are either preventable, as in preventing cardiovascular events by... ting conditions once they have occurred. Although various definitions for... ty demonstrated high rates in the United States. Cardiovascular disease is... ly 800,000 per year) and many of them (e.g., heart disease, stroke, and

Million Hearts® Webinar Series

Nurse Practitioners and Million Hearts® Partnering to Achieve Blood Pressure Control

Team-based Care & Workflow

- Team leadership and role definition
 - Situational
 - Requires shared vision & mission
- Communication
- Opportunities for engagement
- Align system work and workflow protocols
 - What is the goal of each “patient touch”?



Recommended Adult Measures

- **Controlling High Blood Pressure** (Clinical Process/Effectiveness)
- Use of High-Risk Medications in the Elderly (Patient Safety)
- **Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention** (Population/Public Health)
- Use of Imaging Studies for Low Back Pain (Efficient Use of Healthcare Resources)
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (Population/Public Health)
- **Documentation of Current Medications in the Medical Record** (Patient Safety)
- **Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up** (Population/Public Health)
- **Closing the referral loop: receipt of specialist report** (Care Coordination)
- Functional status assessment for complex chronic conditions (Patient and Family Engagement)

Example of a Clinical Registry

SM = Self Management
Indicates if an action
plan was created.

1	2	3	4	5	6	7	8	9	10	11	12
Name	DOC SM	BP DATE	BP/s	BP/d	LDL Date	LDL	A1c DATE	A1c	DIABETIC	SMOKER	DATE ASKED IF SMOKES
Patient A	NO	2/21/2011	127	70	11/30/2010	93			NO	NO	11/20/2010
Patient B	YES	2/15/2011	110	55	2/15/2011	145	9/25/2010	11.3	YES	YES	2/15/2011
Patient C	NO	4/7/2010	158	87	4/11/2010	81	4/11/2010	6.7	YES	NO	3/15/2008
Patient D	YES	1/20/2011	148	95	12/14/2010	170	12/14/2010	8.9	YES	YES	12/12/2009
Patient E	NO	10/28/2010	129	72	12/10/2010	54	12/10/2010	9.6	YES	YES	3/30/2010
Patient F	NO	8/21/2010	125	88	4/20/2010	125			NO		
Patient G	YES	6/24/2010	149	85	4/16/2009	102			NO	NO	12/2/2008
Patient H	NO	3/5/2011	147	90	3/5/2011	81	3/5/2011	12.1	YES	NO	3/5/2011
Patient I	NO	1/29/2010	120	64	2/3/2010	65			NO	NO	12/22/2004
Patient J	YES	1/5/2011	117	81	1/5/2011	112	1/5/2011	5.9	YES	YES	7/5/2010
Patient K	YES	7/24/2008	152	85	7/14/2008	157			NO		

Most current date
that blood pressure
measured

Most current date
that LDL cholesterol
measured

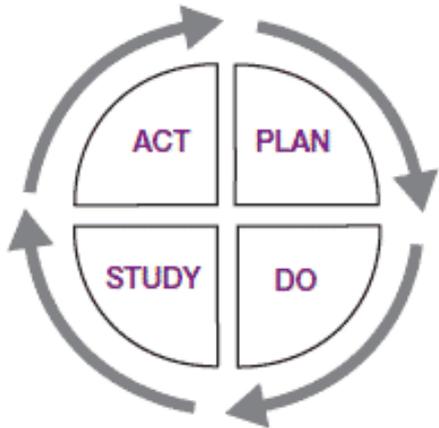
Most current date that
HbA1c measured

Indicates the most
recent date patient was
asked about smoking

Module 20 Appendix B: Facilitating Panel Management, 2011

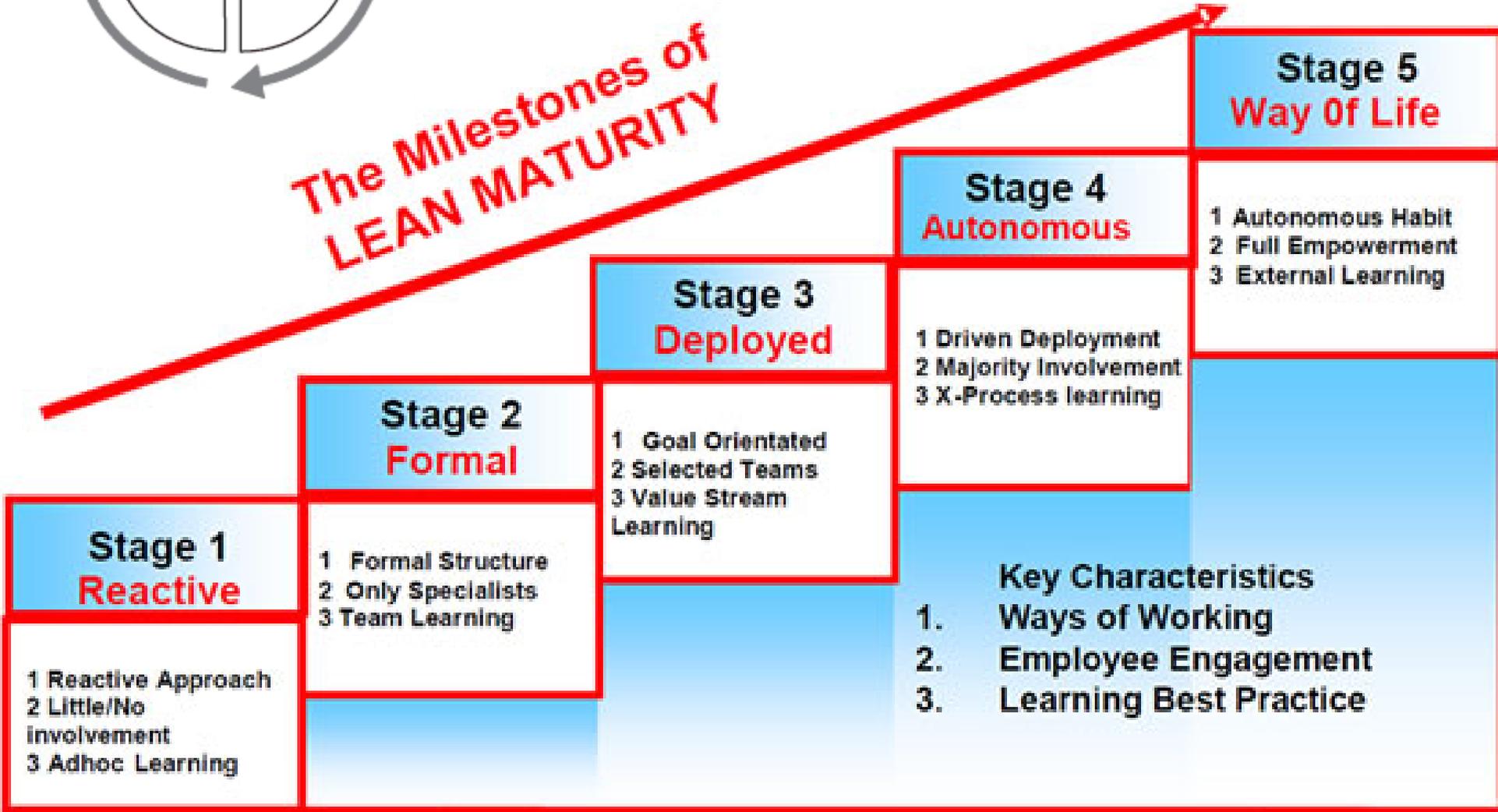
Dr. Thomas Bodenheimer, M.D., M.P.H., and Amireh Ghorob, M.P.H.

<http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod20appendixb.html>



How do we adjust?

The Milestones of LEAN MATURITY



Million Hearts[®] Cardiovascular Disease Risk Reduction Model

Background & Rationale

- Heart attack and stroke (ASCVD) are leading causes of death and disability
- In the past
 - Risk reduction focused on specific process measure targets, i.e. LDL cholesterol level and blood pressure, with the same targets applied to all patients
 - Currently, risk factors are discussed as independent conditions rather than risk factors contributing to ASCVD
 - Patients have little idea of their actual risks of heart attack and stroke
- What the model will change
 - Uses data-driven, widely accepted predictive algorithm to give individualized 10-year risk score for ASCVD to each beneficiary
 - Providers get value-based payment depending on absolute risk drop across entire panel, necessitating population health management

ACC/AHA Pooled Cohort ASCVD Risk Estimator – Examples

The screenshot shows the ACC/AHA Pooled Cohort ASCVD Risk Estimator app interface. At the top, there are navigation tabs for 'Estimator', 'Clinicians', 'Patients', and 'About'. The main header is 'ASCVD Risk Estimator*'. Below this, there are two columns: '10-Year ASCVD Risk' and 'Lifetime ASCVD Risk'. The 10-year risk is displayed as 59.9% (calculated risk) and 7.8% (risk with optimal risk factors**). The lifetime risk section includes a warning icon and text: 'Lifetime Risk Calculator only provides lifetime risk estimates for individuals 20 to 59 years of age.' Below the risk calculations is a 'Recommendation Based On Calcul...' button with a right arrow. The input fields are: HDL - Cholesterol (mg/dL) with a value of 46; Systolic Blood Pressure with a value of 150; Treatment for Hypertension with a toggle set to 'Y'; and Diabetes with a toggle set to 'Y'.

How Risk Calculators Enhance High Value Care:

Joe Smith is a 65 year old African American man who smokes, has elevated cholesterol, and a borderline elevated blood pressure. His 10-year risk is 31.1% percent (high).

Alan Jones is a 66 year old white man with mildly elevated blood pressure (e.g. SBP 135 mm Hg), but no other risk factors, so his 10-year-risk is 11% (low).

Treating Joe Smith's blood pressure (traditionally valued the same by current one-size-fits-all measure) has a much larger impact on risk of ASCVD than treating Alan Jones's blood pressure

Model Aim and Eligibility

Aim

- Offer provider incentives for risk stratification, shared decision-making and enhanced accountability across a provider's entire Medicare FFS patient panel
- Reduce predicted 10-year ASCVD risk, reduce the incidence of heart attacks & strokes

Practice Eligibility

- At least 1 professional: As defined by the PQRS definition
- Enrolled and eligible to bill for Medicare Part B
- Using an Office of the National Coordinator (ONC) certified Electronic Health Record
- Have met the criteria for the Medicare EHR Incentive Program in performance year 2015

Model Design Framework

- 5 year Model Test
- Randomized Evaluation Design
 - Planned 360 control and 360 intervention practices, with built in 20 percent attrition anticipated
 - Roughly 150,000 Medicare FFS beneficiaries in each arm
- Programmatic Elements
 - Risk Stratified Care
 - Population Health Management
 - Shared Decision Making
 - Individual Risk Modification Planning
 - Team-Based Care
 - Quality and Clinical Data Reporting

Important Features of This Model

- First CMS model to incentivize reduction in a predicted future risk, paving way for future innovative approaches to value-based prevention (e.g. reduction in other preventable conditions)
- Focus on meaningful, patient-centered risk score
- Transparent, easily understood provider financial incentive
- Rigorous design, with clustering at practice level, at large scale (360 intervention and 360 control practices, enrolling almost 300,000 Medicare FFS beneficiaries)
- Path towards nationwide scaling if model test is successful

Important Dates

<http://innovation.cms.gov/initiatives/Million-Hearts-CVDRRM/>

Date	Activity
May 2015	Announcement
May – August 2015	LOI Period
July - August 2015	Application Period
August – November 2015	Application Review & Selection
November 2015	Awards
January 2016	Model Go Live

References & Further Reading

- Million Hearts website: <http://millionhearts.hhs.gov/>
- Medscape team-based approach in treating obesity
http://www.medscape.org/viewarticle/842686?src=wnl_cme_invitations
- *Proia, et al. 2014. Team Based Care and Improved Blood Pressure Control: A Community Guide Systematic Review. Am J Prev Med 47(1):86-99.*
- *Bodenheimer T and BY Laing. The Teamlet Model of Primary Care. Sept/Oct 2007. Annals of Family Medicine 5(5):457-461.*
- AHRQ → SYSTEM REDESIGN resources
<http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/index.html>
- Institute for Healthcare Improvement: www.ihl.org
- PCMH toolkit: <http://www.familydocs.org/practice-resources/pcmh>

Questions?

Ashby Wolfe, MD, MPP, MPH
Chief Medical Officer, Region IX
Centers for Medicare and Medicaid Services
90 Seventh Street, Suite 5-300
San Francisco, CA 94103
(Ph) 415.744.3631
ashby.wolfe1@cms.hhs.gov