Million Hearts®
Hypertension and Nursing

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Heart Disease and Stroke

Leading Killers in the United States

• More than 1.5 million heart attacks and strokes each year
• Cause 1 of every 3 deaths
  – 800,000 deaths
  – Leading cause of preventable death in people <65
> $300B in health care costs and lost productivity
• Greatest contributor to racial disparities in life expectancy
Heart Disease is the #1 Cause of Death in the US
~75 Million have Hypertension

200,000
At least 200,000 deaths from heart disease and stroke each year are preventable.

6 in 10
More than half of preventable heart disease and stroke deaths happen to people under age 65.

2x
Blacks are nearly twice as likely as whites to die from preventable heart disease and stroke.

US adults have hearts 7 years older than they should be.

Hypertension and Smoking are key drivers of Heart Age.

MMWR: Vital Signs: Predicted Heart Age and Racial Disparities in Heart Age Among U.S. Adults at the State Level. Published September 4, 2015. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6434a6.htm?s_cid=mm6434a6_w

MMWR: Vital Signs: Avoidable Deaths from Heart Disease, Stroke, Hypertensive Disease – United States, 2001-2010. Published September 6, 2013. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6235a4.htm?s_cid=mm6235a4_w
Key Components of Million Hearts®

**Keeping Us Healthy**
*Changing the environment*

- Aspirin when appropriate
- Blood pressure control
- Cholesterol management
- Smoking cessation

**Excelling in the ABCS**
*Optimizing care*

- Focus on the ABCS
- Health information technology
- Innovations in care delivery

Be one in a Million Hearts®
millionhearts.hhs.gov
Only Half of Americans with Hypertension Have It Under Control

75 MILLION ADULTS WITH HYPERTENSION (32%)

54%

46%
(35 M)

34.6M US Adults with uncontrolled HTN

- 11.5M Aware and treated
- 16.1M Aware and untreated
- 7.0M "Unaware"

Source: 2013-2014 National Health and Nutrition Examination Survey
Most People with Uncontrolled HTN are Insured and Seen Regularly

- **89%** with usual source of care are insured.
- **85%** with health insurance are seen regularly.
- **74%** of those seen regularly received care at least 2 times.

Actions that Improve Hypertension Control

Evidence-based, Team-Delivered

16.1M Aware and Treated but Uncontrolled
  – Standardizing and Simplifying Treatment
  – Medication Adherence
  – Self-monitoring with Clinical Support

• Recognizing and Rewarding Success
## Hypertension Control Change Package

### Table 1. Hypertension Control Change Package—Key Foundations (continued)

<table>
<thead>
<tr>
<th>Change Concepts</th>
<th>Change Ideas</th>
<th>Tools and Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overlook a flowchart for how hypertensive patients will be proactively tracked and managed</td>
<td>- <a href="http://millhearts.hhs.gov/Docs/HYPN_CHANGE_PACKAGE.pdf">http://millhearts.hhs.gov/Docs/HYPN_CHANGE_PACKAGE.pdf</a></td>
<td>- <a href="http://www.wa.gov">http://www.wa.gov</a></td>
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### Table 2. Hypertension Control Change Package—Population Health Management

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<tbody>
<tr>
<td>Use a Registry to Identify, Track, and Manage Patients with HTN</td>
<td>Use a defined process for outreach (e.g., via phone, mail, email, text) managed to patients with uncontrolled HTN, and those otherwise needing follow-up</td>
<td>- <a href="http://www.wa.gov">http://www.wa.gov</a></td>
</tr>
</tbody>
</table>

### Access the Change Package at:

Hypertension Control Change Package

Focus Areas

1. Key foundations
2. Population health management
3. Individual patient supports

→ Hypertension control case studies
Change Concept

- General notions that are useful in the development of more specific ideas for changes that lead to improvement

Change Idea

- Actionable, specific ideas for changing a process

Tools & Resources

- Can be adapted by or adopted in a health care setting
Train and Evaluate Direct Care Staff on Accurate Blood Pressure Measurement and Recording

1. Provide Guidance on Measuring BP Accurately

2. Assess Adherence to Proper BP Measurement Technique

Change Concept

Change Ideas

Tools & Resources
How Does a Protocol Improve Control?

- Outlines process for management of patients resistant to treatment
- Raises patient and team “radar” about hypertension
- Reduces variation in clinical practice and ensures evidence-based care for all patients with hypertension
Trends in Factors That Promote Adherence to Antihypertensive Medication (AHM), 2009 vs. 2014, IMS Health

Self-Measured Blood Pressure Monitoring (SMBP): Action Steps for Clinicians

- Guidance for clinicians on SMBP
  - Prepare Care Teams to Support SMBP
  - Select and Incorporate Clinical Support Systems for SMBP
  - Empower Patients to Use SMBP
  - Encourage Coverage for SMBP Plus Additional Clinical Support

- Teach patients to use monitors
- Check home machines for accuracy
- Suggested protocol for home monitoring
Barriers to Implementation

- Coverage/reimbursement
- Uptake by clinical community
  - Training issues
  - Capacity
  - Confidence in patients’ readings
  - Reimbursement for the time
- Inclusion of SMBP values
  - into patient portals and EHRs for use in HTN management
  - Into clinical quality measures
- New technologies (e.g. cuff-less smart phone apps)
Wisconsin Hypertension Control Champions

- **2012**
  - Ellsworth Medical Clinic, Ellsworth

- **2013**
  - River Falls Medical Clinic, River Falls
  - ThedaCare, Appleton
Actions that Improve Hypertension Control

Evidence-based, Team-Delivered

Untreated / Not on Meds

11.5M U+ U and 7.0M A and U

- Find the Undiagnosed
- Diagnostic protocol – close the loop
- Standardized treatment protocol
Most People with Uncontrolled HTN are Insured and Seen Regularly

- Health Insurance:
  - Yes: 89%
  - No: 11%

- Usual Source of Care:
  - Yes: 85%
  - No: 15%

- # Times Received Care in Past Year:
  - ≥2: 74%
  - 1: 26%
  - None: 0%
Finding Undx Hypertension: 4-Step Process

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

Finding Undx Hypertension: 4-Step Process

Finding Undiagnosed Hypertensive Patients
“Hiding in Plain Sight”

11,000/120,000 CHC patients had high BP measurements, but no HTN dx
Hiding in Plain Sight: 
*Resources to Help Find the Undiagnosed*

- **Hypertension Prevalence Estimator** – For practices/health systems to use to estimate their expected hypertension prevalence among their patient population

- **Whiteboard animation** – a creative depiction of the “hiding in plain sight” phenomenon and what clinical settings can do

- **National Association of Community Health Centers – Consolidated Change Package** - leveraging health IT, QI, and primary care teams to identify hypertensive patients hiding in plain sight

Tools you can use and other RESOURCES
Million Hearts® Microsite


- Includes Million Hearts® evidence-based protocols, action guides, and other QI tools
- Syndicates Million Hearts® content through your website for your clinical audience
- A small amount of code - customizable by color and responsive to layouts and screen sizes - is needed to embed microsite.
- Content is cleared and continuously maintained by CDC

Go to CDC’s Public Health Media Library for more information: https://tools.cdc.gov/
Benefits of Using the Million Hearts® Microsite

• Syndicated content is updated automatically
  – Ends the need to manually cut and paste static information and links into your site.
  – Requires little to no maintenance

• Ensures you have the latest scientifically sound and credible Million Hearts® resources on your website for your clinical audience

• Extends the reach of key Million Hearts® messages and tools to targeted users

• Aligns Million Hearts® messaging for maximum impact
Million Hearts Partners at Work on Hypertension Control

- 50 State Health Departments and District of Columbia
- AHRQ Evidence Now (2018)
- CMMI Million Hearts Risk Reduction Model (2021)
- CMS’ QIN-QIOs focus on the ABCS (2019)
- CDC 2016 Champions Program (2017)
- CMS Transforming Clinical Practice Initiative
- CDC HTN project with Y, NACHC, ASTHO (2018)
- NINDS Mind Your Risk campaign on Brain Health (2018)
- Million Hearts Cardiac Rehab Collaborative (2021)
CARDIAC REHABILITATION

SAVING LIVES  🥰  RESTORING HEALTH  🥰  PREVENTING DISEASE

BENEFITS OF CARDIAC REHABILITATION

Benefits to People

Those who attend 36 sessions have a

47% lower risk of death and

31% lower risk of heart attack than those who attend only one session.

Benefits to Health Systems

36 One Hour Sessions

Supervised Exercise
Patient Counseling
Nutritional/Lifestyle Education

Costs per year of life saved range from $4,950 to $9,200 per person.
Cardiac rehab participation also reduces hospital readmissions.
Many People Who Can Benefit Are Not Being Referred

Minority status predicts lower referral and participation rates.

Women, minorities, older people and those with other medical conditions are under-referred to cardiac rehab.

One of the best predictors of cardiac rehab referral is if the eligible person speaks English.

Asian Americans are 18 times more likely to have limited English, compared to whites.

Black women are 60% less likely to be referred and enroll in cardiac rehab programs, compared to white women.

We Know What Works To Improve Referral Rates

Automatic, systematic referral to cardiac rehab at discharge can help connect eligible people with these programs.

Strong coordination between inpatient, home health, and outpatient cardiac rehab programs boosts referral rates, as well as participation rates and outcomes.

Patients' medical teams -- and families -- can support and encourage participation in cardiac rehab programs.

Awareness campaigns should be targeted to people and caregivers.

ONLY 20% OF ELIGIBLE PATIENTS ARE REFERRED...

... AND ONLY HALF OF REFERRED PATIENTS ACTUALLY PARTICIPATE...
Changing the Environment: Reducing Sodium Intake

- Develop and implement efforts to increase public awareness
- Help reduce sodium in diets
- Adopt sodium standards
- Encourage reductions in amount of sodium in foods sold or served
- Sodium reduction resources
  - HHS and GSA Health and Sustainability Guidelines for Federal Concessions and Vending Operations
  - FDA.gov/Food/Guidance Regulation /Guidance
  - 2015-2020 Dietary Guidelines for Americans
  - CDC: Sodium Reduction Resources for Everyone
  - Center for Science in the Public Interest: Healthier Food Choices for Public Places
Healthy Is Strong

- **Target Audience**
  Focused on patient empowerment and activation to engage with providers and healthcare systems.

- **Healthcare Provider & Healthcare Systems**
  Focused on connecting the target audience with health professionals and the systems that they work within.

- **Community Partners & Local Stakeholders**
  Promoted awareness of HIS campaign by stimulating behavior change among target audience.

[http://millionhearts.hhs.gov/learn-prevent/healthy-is-strong.html](http://millionhearts.hhs.gov/learn-prevent/healthy-is-strong.html)
Million Hearts® Accomplishments*

Changing the Environment

Reduce Smoking
Almost 4 million fewer cigarette smokers†

Reduce Sodium Intake
Voluntary Sodium Guidance to Industry issued 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.
‡ http://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/ucm494732.htm
§ http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm372915.htm.
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§

* Note this is a select set of notable Million Hearts® accomplishments.
† 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.
Future of Million Hearts

- CDC and CMS continue to co-lead
- ABCS will remain in
- Sodium will remain in – and we need your assistance – especially thinking about the power of procurement
- Clearer emphasis on Priority Populations
Million Hearts 2.0 Concept

**Keeping People Healthy**

**Excelling in the ABCS**

**Healthcare Actions:**
- Teams
- Technology
- Innovative Care Delivery

**Public Health Actions:**
- Sodium Reduction
- Tobacco Control
- Air Quality PM 2.5
- Physical Activity

**Focusing on Risk Priority Populations:**
- African Americans
- 45-64 year olds
- Have had a HA or Stroke other

**Have had a HA or Stroke other**
Questions +
Thank You!