



The Office of the National Coordinator for  
Health Information Technology



# Health IT and Million Hearts

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Putting the **I** in **HealthIT**  
[www.HealthIT.gov](http://www.HealthIT.gov)



Building Million Hearts into Meaningful Use of Electronic Health Records (EHRs)

Partnering between Regional Extension Centers (RECs) and Quality Improvement Organizations (QIOs)

Developing Tools for Implementing Clinical Decision Support Aligned to Million Hearts

Conducting Developer App Challenges

Aligning Quality Measures

Highlighting Beacon Community Interventions

## Health IT enables:

- Quality Improvement
- Behavior change and improved workflow through clinical decision support
- Population management
- Registries and patient reminders

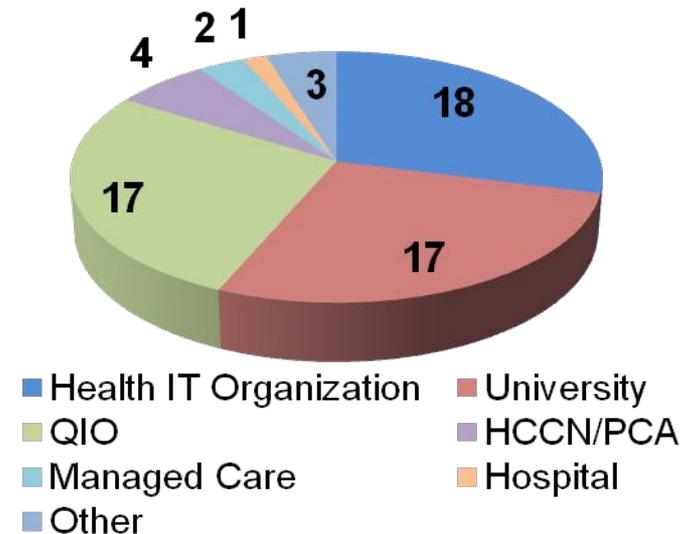
# Building Million Hearts into Meaningful Use of EHRs

Domain	Million Hearts Measures	Meaningful Use Notes
Aspirin Use	<b>PQRS Measure #204 (NQF 0058):</b> Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	MU Stage 1- menu option
Blood Pressure Screening	<b>[Proposed] PQRS Measure #M125:</b> Preventive Care and Screening: Screening for High Blood Pressure	Working to align
Blood Pressure Control	<b>PQRS Measure #235 (NQF 0018):</b> Hypertension: Controlling High Blood Pressure	MU Stage 1- menu option
Cholesterol Control - Risk Stratified	<b>[Proposed] PQRS Measure #M119:</b> Preventive Care and Screening: Cholesterol a. fasting Low Density lipoprotein (LDL) Test Performed, b. Risk-Stratified Fasting LDL	Working to align
Cholesterol Control - High-risk only	<b>PQRS Measure #202 and #203 (NQF 0075):</b> Ischemic Vascular Disease {I VD}: Complete lipid Panel and Low Density lipoprotein {LDL-C} Control	MU Stage 1- menu option
Cholesterol Control - High-risk only	<b>PQRS Measure #2 (NQF 0054):</b> Diabetes Mellitus: Low Density lipoprotein {LDL-C} Control in Diabetes Mellitus	MU Stage 1- menu option
Smoking Cessation	<b>PQRS Measure #225 (NQF 0028):</b> Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	MU Stage 1- core

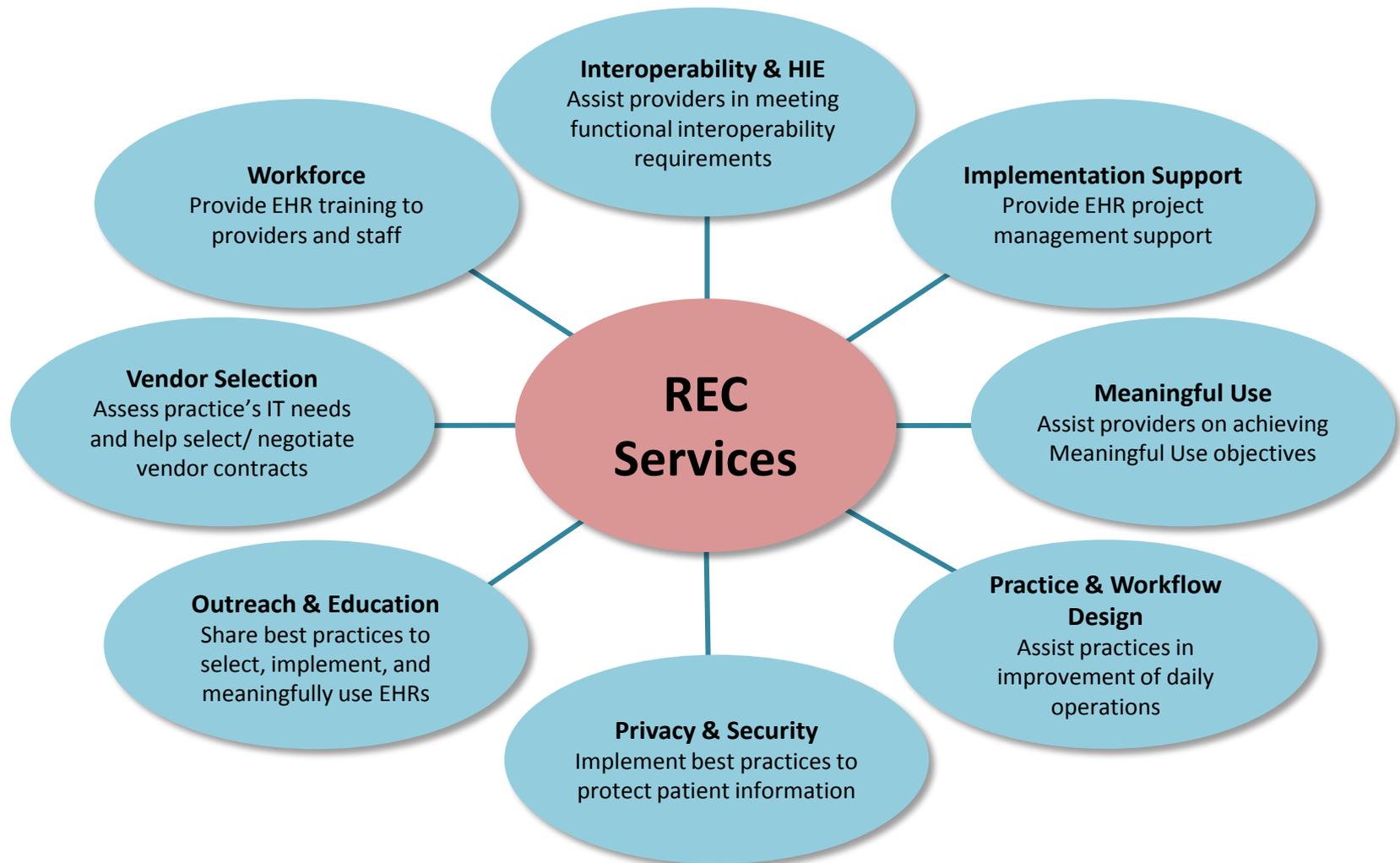
**Goal: 100,000 priority primary care providers achieve meaningful use (MU) by 2014**

- Not-for-profit organizations
- Experts in EHR adoption
- Provide “on-the-ground” technical assistance
- Extensive stakeholder partnerships
- Focused on achieving MU

## Organizations Sponsoring RECs

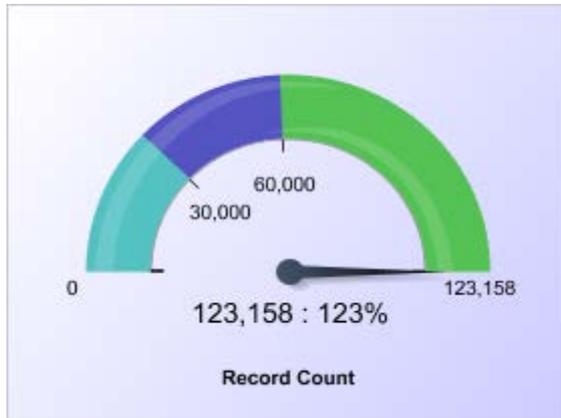


# RECs Cover the Full Range of Services



# REC Program Success To-date

Primary Care Providers (PCP)  
Enrolled



PCP live on an Electronic  
Health Record (EHR) System



PCP to Meaningful Use



Total Ambulatory PCP = 308,000  
Total Ambulatory Specialist ~350,000

# REC Connecting Providers to Three Part Aim Programs

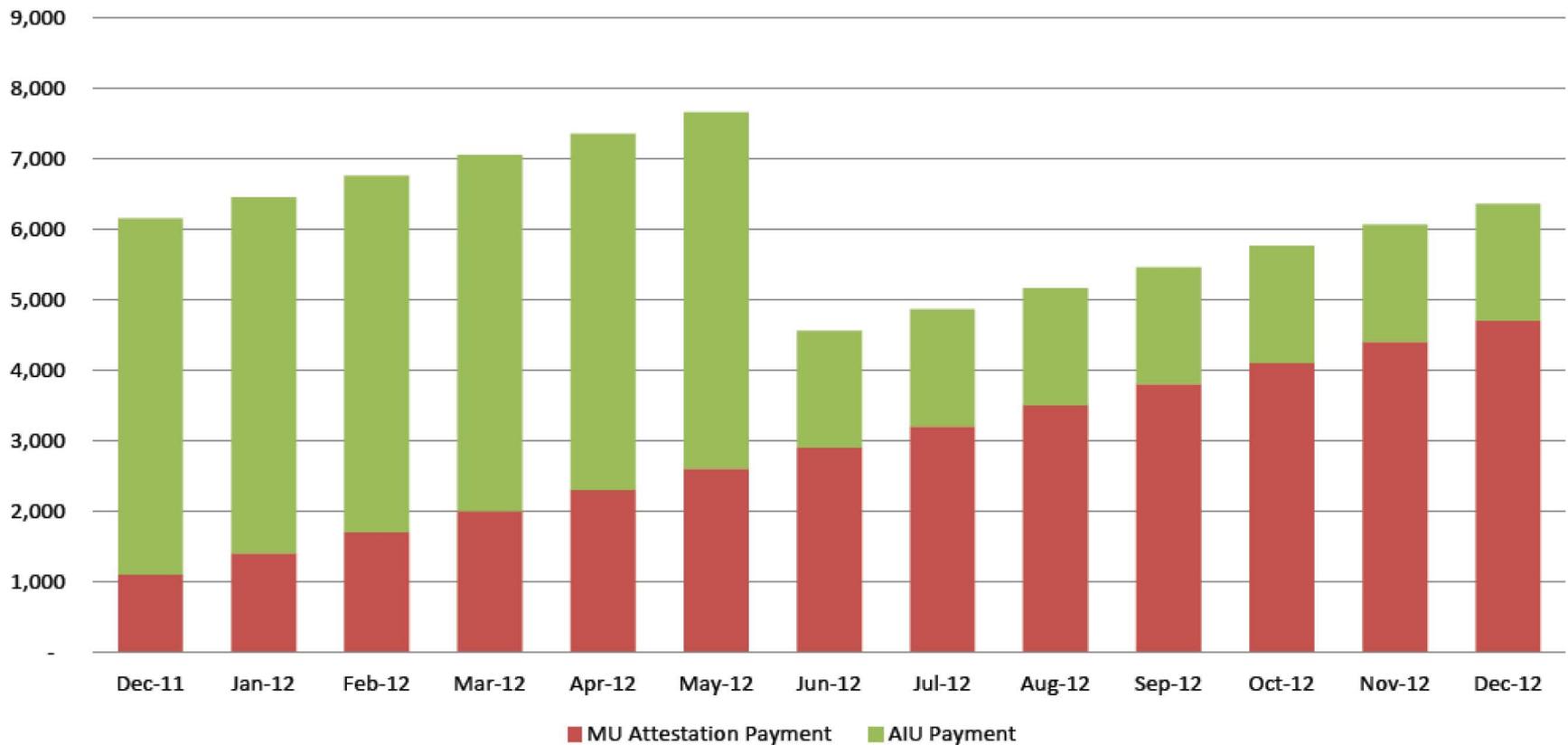
- Regional Extension Center's are being to assist their providers to participate in a diverse set of programs aimed at
  - 1) improving health care quality,
  - 2) health care efficiency/lowering health care cost, and
  - 3) Improving population health.
- A recent survey identified that REC's collectively are currently working on over 190 different programs including:

Type of Initiative	PCMH	ACO	Part. for Patients/ Care Trans.	Payer Pay for Performance	Innovation Challenge	Million Hearts	Bundled Payments	Other Three-Part Aim program
# of responses*	52	18	23	27	17	14	4	45
% of respondents	83%	32%	36%	45%	32%	26%	8%	45%

\* Several REC are working on several different Tree Part Aim Programs

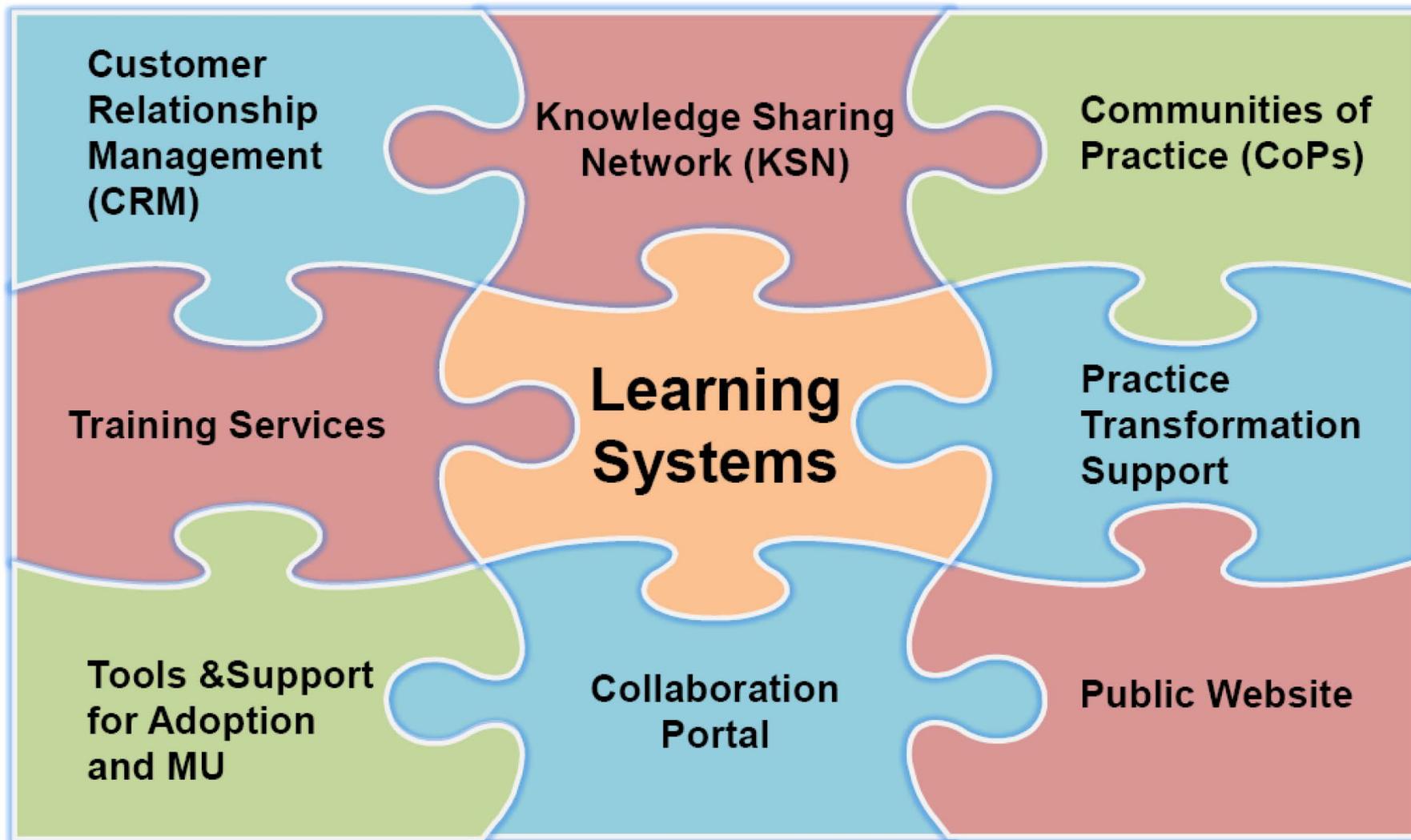
# Goals for 2012: The Year Of MU!

## Beacon and REC Targets for Provider Payment 2012



# HITRC's Central Role Supports Health IT Optimization





- RECs and CMS Quality Improvement Organizations (QIOs)
  - Partnering to provide technical assistance on a large scale to primary care providers
  - Assist providers in using EHRs (e.g., clinical decision support, data reports, registries) to track and improve care related to 8 prevention measures, including Million Hearts ABCS

# Clinical Decision Support Aligned to Million Hearts

- Working to develop a MOU between ONC and CMS
  - Goal is to engage federal stakeholders in strategic CDS planning to support ABCS objectives
  - Introduce and revise a draft CDS strategy to improve outcomes
    - Providing appropriate information
    - to the appropriate individual
    - in the appropriate format
    - through the appropriate channel
    - at the appropriate point in workflow
  - Establish roles for further refining and executing the CDS strategy

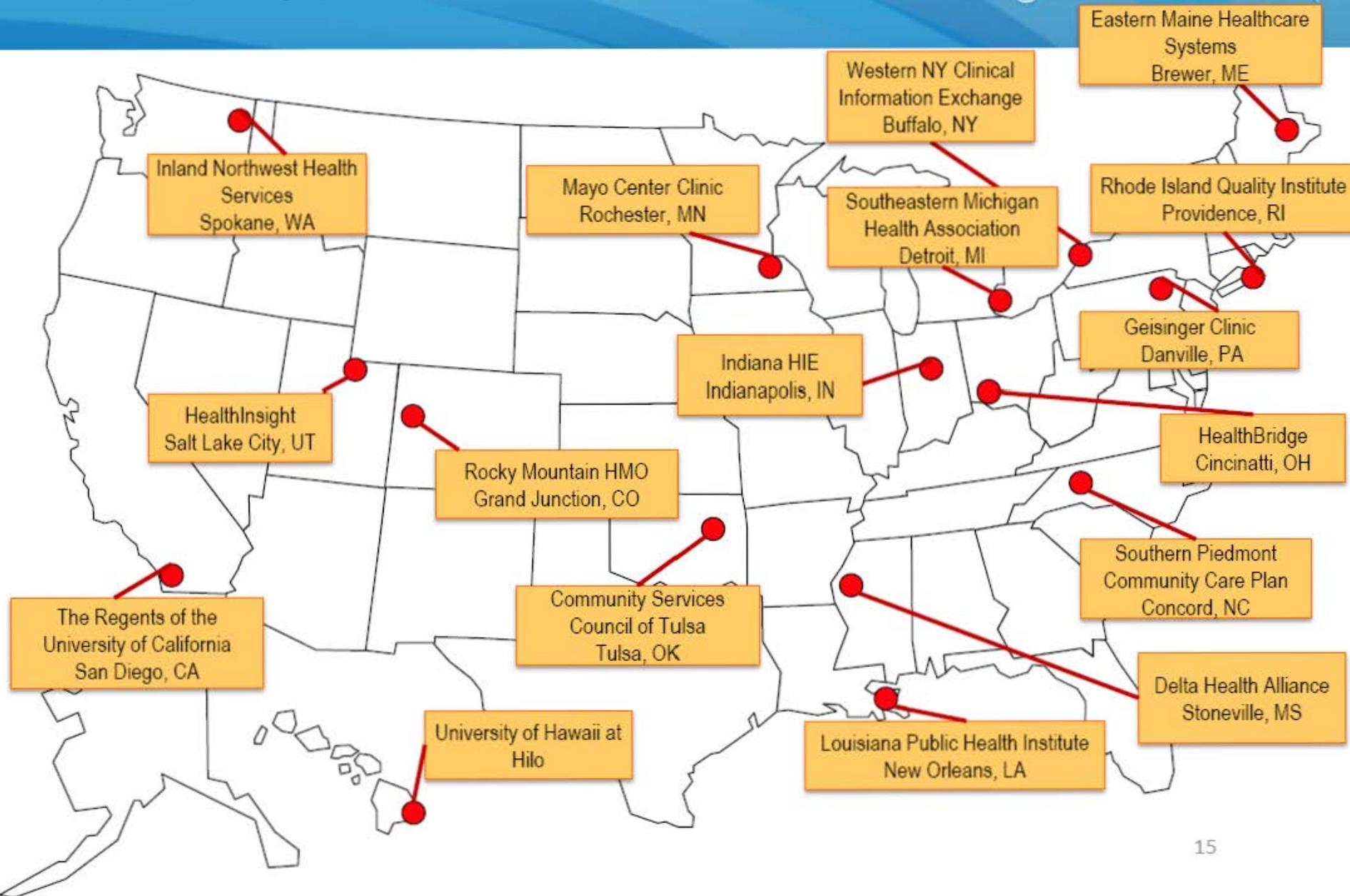
- ONC launched *One in a Million Hearts* challenge
  - Call to innovators and developers to create an application that activates and empowers patients to improve their heart health
  - Over 20 teams currently signed up
  - Winner will be announced January 20, 2012

## **17 grantees each funded ~\$12-15M over 3 yrs to:**

- **Build and strengthen** health IT infrastructure and exchange capabilities — positioning each community to pursue a new level of sustainable health care quality and efficiency over the coming years.
- **Demonstrate improvement** in cost, quality, and population health
- **Test innovative approaches** to performance measurement, technology integration, and care delivery to accelerate evidence generation for new approaches

# Beacon Communities

Putting the **I** in Health**IT**



# Beacon Alignment with MH: Intervention Examples

## Prediction

- Archimedes risk stratification based on 5-year risk of heart health (Example: Colorado and Tulsa, OK Beacon Communities)
- Elevated blood pressure alerts (and other vital readings) transmitted from home-based tele-monitoring devices to E.H.Rs in physician offices via HIE.

## Prevention

- Text-based smoking cessation reminders for high risk patients (Example: Bangor, ME Beacon Community)
- Clinical decision-support for screening and medication alerts (New Orleans, SE Minnesota)

## Management

- Ambulatory care management for high risk patients, and for high risk CHF patients post discharge (Example: RI, Keystone, North Carolina and Bangor, ME Beacon Communities)

## Acute Intervention

- EMS Electrocardiogram sent to area hospital to ensure cath lab/provider team readiness immediately upon arrival (Example: San Diego Beacon Community)

# Questions?

- Please contact:
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