

Million Hearts® Model Promising Practice Case Study

Participant Spotlight

Hunterdon Cardiovascular Associates
Flemington, NJ



This Million Hearts® Model participant, Hunterdon Cardiovascular Associates (HCA), serves more than 12,000 patients, nearly half of which have been diagnosed with hypertension. Their major challenge has been to help patients **address modifiable risk factors**, such as inactivity and unhealthy diets.

To support patients in their hypertension control journey, HCA used a combination of team-based care, at-home blood pressure monitoring, and – when possible – 24-hour ambulatory monitoring.

In the care delivery setting, HCA ensures that patients are seen by a multidisciplinary team – including cardiologists, nurses, and medical assistants. During their visit, patients are oriented to the value of home readings and instructed on correct measurement techniques. The organization also took steps towards **validating Remote Patient Monitoring (RPM) readings** with the practice's monitors.

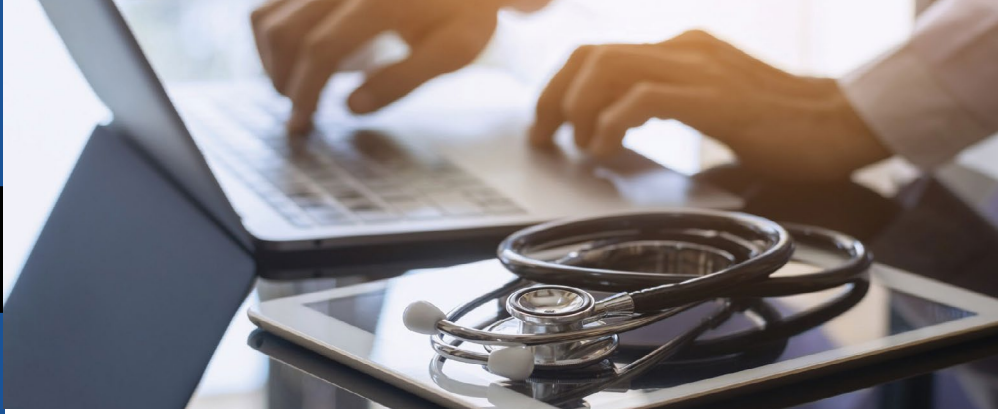
HCA set up Electronic Health Records alerts to notify care providers when patients' blood pressure readings are out of range, enabling teams to follow-up with patients who may be increasing in risk or using blood pressure monitors incorrectly.

HCA paired these self-management practices with team-based care by connecting patients with additional resources, such as dietitians and smoking cessation counselors.

By **enabling patients** to engage in self management, HCA was able to establish a hypertension control rate of greater than 80% among its patients in 2019.

“HCA empowers patients to take control of their blood pressure management through various avenues – **including strong patient education** – to ensure adherence to medical therapy and educating individuals on the importance and impact of healthy lifestyle changes.”

~ HCA Advanced Practice Provider



The aim of the Centers for Medicare & Medicaid Services (CMS) Innovation Center's Million Hearts® Cardiovascular Disease Risk Reduction Model (Million Hearts® Model) is to prevent first time heart attack and stroke in high risk Medicare beneficiaries. The model aim was supported by primary model drivers. This case study spotlights one of our participant organizations' innovative implementation of the "Shared Decision Making" model driver.

Promising Practice: The Role of Digital Health Solutions in Patient Self-Management

Electronic Health Records (EHRs) offer healthcare organizations the ability to readily access patient data.

The ongoing Public Health Emergency has changed how the medical community can safely treat patients and unearthed a growing need to maintain Medicare patients in their homes. Digital health solutions can help to reduce patients' chronic disease risk factors and support chronic condition self-management for cardiovascular disease, high blood pressure, and diabetes.

The use of digital health solutions, including telehealth interventions, can improve:

- **Medication adherence**, such as outpatient follow-up and self-management goals
- **Dietary outcomes**, such as eating more fruits and vegetables and reducing sodium intake
- **Clinical outcomes**, such as blood pressure control



Million Hearts® Model Sustainable Tactics to Consider when Addressing Social Barriers to Care

RPM can empower patients to manage their health and participate in their care plan. It can also provide clinicians with a more holistic view of a patient's health over time, allowing them to better understand a patient's medication adherence, and improve chronic condition care management.²



Blood Pressure Cuff: Home blood pressure monitoring can be helpful for patients diagnosed with high blood pressure, hypertension, or risk-factors for developing these conditions.



Digital Bluetooth Scale: This technology allows patients to self-monitor weight loss, offering a digital solution tool aimed at preventing diabetes, a co-morbidity factor for cardiovascular disease.



Blood Glucose Monitor: A home test that allows patients to self-monitor glucose levels. Patients and providers can use the results to determine daily adjustments to care treatment and understand how risk factors, such as diet and exercise, change glucose levels.



Million Hearts® Model Practical Tools: Additional Digital Health Solutions and Strategies

- **Text Messaging:** SMS reminders are a low-cost method to support patient self-management and improve medication adherence. Patients can receive medication and appointment reminders via text message, as well as tailored education messages.
- **Web-based content and applications:** Adopt user-centered approaches when building web-based content and applications to promote health education on cardiovascular disease prevention.
- **Interactive content:** Many RPM tools offer interactive features, such as real-time video or interactive self-care tools that can engage patients in their care. Patients can also use digital health solutions to send their health data directly to their healthcare provider.