MILLION HEARTS COLLABORATIVE NEW YORK

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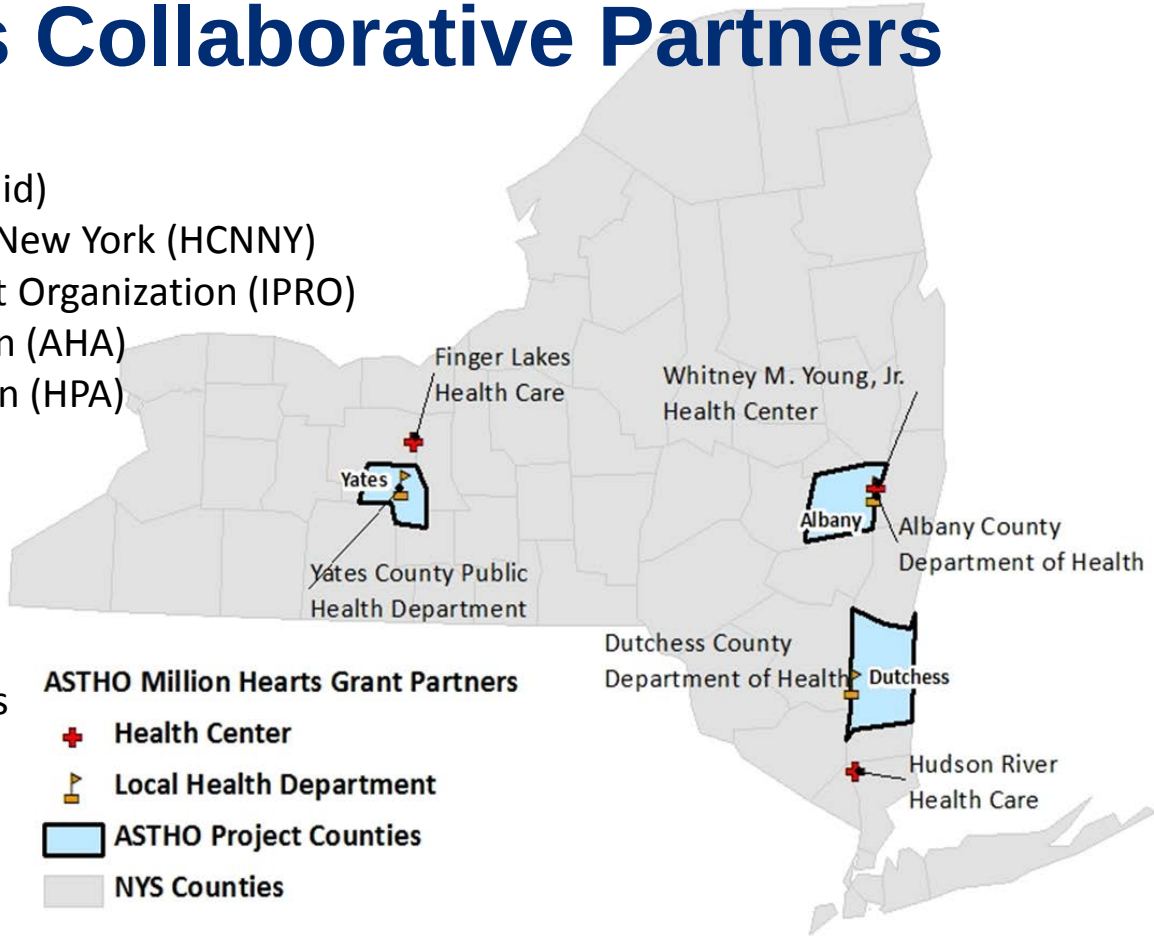
New York's Collaborative Partners

Statewide Partners:
-NYSDOH (including Medicaid)
-Health Center Network of New York (HCNNY)
-NYS's Quality Improvement Organization (IPRO)
-American Heart Association (AHA)
-NYS Health Plan Association (HPA)

Regional Partner:
RHIO (HIXNY)

Local Partners:
County Health Departments
FQHCs
Americore workers
Cornell Coop Extension

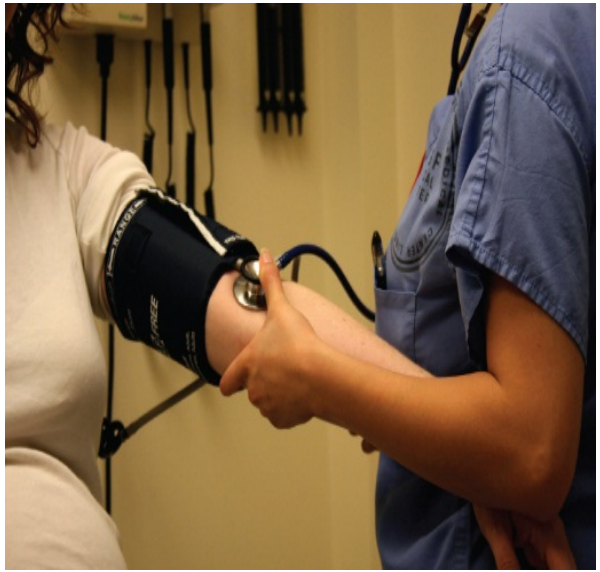


New York's Million Hearts Programmatic Innovations

Project Aim: 10% improvement in 1 year in HTN control and identification of undiagnosed HTN.

FQHCs used the IHI model for improvement to implement system changes via PDSA cycles to improve HTN control:

- Established clinical treatment protocols (CDC)
- Implemented systems changes in the FQHCs
- Implemented home BP monitoring program:
  - Automated BP monitors
  - Educational materials developed by AmeriCorps collaborators.



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New York's Million Hearts Data Innovations

1. HCCNY provided data extracts (HTN registry function) using eClinicalWorks EHR
2. Undiagnosed HTN Metric – developed and piloted.
   - Elevated BPs on 2 occasions with no Dx of HTN.
3. HTN medication adherence using Medicaid datamart.
   - Proportion of days covered (CDC methodology)
   - Primary non-adherence (initial prescription filled?)
4. Population HTN surveillance pilot in one county using HIXNY (RHIO) HIE data to assess:
   - Overall population prevalence,
   - HTN control,
   - Undiagnosed HTN,

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FQHC Hypertension Prevalence

Health Center	Baseline Sep 2013 Rolling 12 Months	Sep 2014 Rolling 12 Months	Net Diff (Percent Change)
Health Center 1	30.5%	30.6%	0.3%
Health Center 2	29.9%	30.6%	2.3%
Health Center 3	40.1%	44.8%	11.6%
Center Average	**33.5%**	**35.3%**	5.5%
National Average (CDC, 2012)	**29.1%**	**29.1%**	

N = 9,512 patients

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FQHC Undiagnosed Hypertension

Health Center	Baseline Dec 2013 Rolling 12 Months	Sep 2014 Rolling 12 Months	Net Diff (Percent Change)
Health Center 1	6.05%	4.39%	-27.44%
Health Center 2	8.18%	6.00%	-26.65%
Health Center 3	6.21%	6.16%	-0.81%
Center Average	**6.81%**	**5.52%**	-19.03%

N= 202

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FQHC Hypertension Control (NQF 0018)

Health Center	Baseline Sep 2013 Rolling 12 Months	Sep 2014 Rolling 12 Months	Net Diff (Percent Change)
Health Center 1	70.2%	79.9%	13.8%
Health Center 2	58.2%	67.1%	15.4%
Health Center 3	52.3%	59.0%	13.0%
Center Average	**56.9%**	**68.7%**	20.7%
HP 2020 Benchmark	**61.2%**	**61.2%**	

N=2,814

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Lessons Learned

- Collaboration across sectors/various partners key to capacity for success
- Senior leadership involvement at all levels in all systems is essential.
- Clear, consistent communication generated common understanding.
- Efficient use of patient registries for planned care accelerates improvement.
- Common EHR platform was critical
- The newly developed and tested undiagnosed HTN metric was successful in identifying patients in need of further evaluation.
- FQHC's highly regarded their collaboration with their LHDs.
- Demonstrated improvement in short timeframe– HTN control improved by an average of 20.7% above baseline across the FQHCs.

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Advancing the Million Hearts Initiative Role of Public Health

State Level

- Engage executive and senior leaders.
- Access resources to support initiate.
- Direct the collaborative; convene internal and external partners.
- Align with other state initiatives.
- Medicaid and Managed Care involvement
- Provide population level data to assess burden and monitor outcomes.
- Promotion of evidence based strategies.
- Monitor performance and report outcomes.
- Spread innovation across other initiatives.

Local Level

- Key Primary Care/Public Health QI team member.
- Collaborate to identify integrated clinical and community priorities.
- Identify and connect Primary Care with community resources and evidence based programing, e.g. Cooperative Extension for Home BP monitoring
- Identify and fill gaps in local program delivery.
- Assist with performance monitoring.
- Going forward: strengthen models of team based care adding Community Heath Workers.

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Opportunities for Improvement

- Enable prescribing a 90 day supply of HTN medication
  - The Evidence: 90 day medication supply increase adherence/control
  - NYS Medicaid allows, but MMC plans are concerned about cost and waste
  - Follow up with Medicaid and MMC plan directors
  - Maintain 30 day prescription until patient is on stable regimen
- Electronic communication when patient fills prescriptions
  - Need to leverage State Health Information Network (SHIN-NY) and develop data sharing agreements between Medicaid and providers
- Notify provider when patients goes to ED
  - Currently health plan is notified.

Expansion and Spread

- CDC 1305 Health Systems Collaborative program grant
  - Expand to 9 FQHC/LHD collaborations (63 clinic sites) by 2018
  - Expand the focus to diabetes control and pre-diabetes ID and follow up
- CDC 1422 State and Local Chronic Disease program grant
  - Improve data exchange using RHIOS and FQHC data warehouse – overcome EHR system differences; Improve alerting and communications over the SHIN-NY
- Inform local implementation of high-level initiatives to redesign systems of care and improve population health outcomes
  - NYS Prevention Agenda – State Health Improvement Plan
  - State Health Innovation Plan (SHIP) / State Innovation Model (SIM) grant
  - Medicaid DSRIP Waiver Program
  - Population Health Improvement Program (PHIP) – regional public health detailing
  - IPRO CMS grant – cardiac population health initiative in 200 primary care practices

NYS PREVENTION AGENDA

Priority Areas:

- Prevent chronic diseases
- Promote a healthy and safe environment
- Promote health women, infants, and children
- Promote mental health and prevent substance abuse
- Prevent HIV, STDs, vaccine-preventable diseases,

  healthcare associated infections

State Health Innovation Plan (SHIP)

Pillars and Enablers

:- Improve access to care for all New Yorkers
- Integrate care to address patient needs seamlessly
- Make the cost and quality of care transparent
- Pay for healthcare value, not volume
- Promote population health
- Develop workforce strategy
- Maximize health information technology
- Performance measurement & evaluation

ALIGNMENT:

NYS Million Hearts Collaborative

MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

Key Themes:

- Integrate Delivery – Performing Provider Systems
- Performance-based payments
- Statewide performance matters
- Regulatory relief and capital funding
- Long-term transformation & sustainability

POPULATION HEALTH IMPROVEMENT PROGRAM (PHIP)

PHIP deliverables:

- Identify, share, and assist with implementation of best practices/strategies to promote population health
- Support and advance the NYS Prevention Agenda
- Support and advance the SHIP
- Serve as resource to DSRIP Performing Provider Systems

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FQHCs

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- Hudson River HealthCare
- Whitney Young Health Ctr.

Local Health Departments

- Yates County DOH
- Dutchess County DOH
- Albany County DOH

Health Information Xchange (Hixny)

IPRO – QIO/QIN

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Thank You

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