

Million Hearts In-Depth Case Study: New York Cardiac Population Health Initiative

The New York Cardiac Population Health Initiative (NY CPHI) is a collaboration between the New York State Department of Health (NYSDOH), IPRO (New York's designated quality improvement organization, or QIO),¹ volunteering practices, and organizations throughout the state. NY CPHI is designed to achieve system-wide practice change and healthcare improvement by providing technical assistance and practice support statewide to improve performance and health outcomes around Million Hearts metrics, including the ABCS² of heart health.

BACKGROUND

Heart disease is the number one killer of New York residents.³ In 2009, New York's cardiovascular-disease-related mortality rate was 254 deaths per 100,000, higher than the national mortality rate of 236 deaths per 100,000.⁴ Furthermore, the prevalence of adults with high blood pressure increased from 22.9 percent in 1999 to 28.6 percent in 2009, and the prevalence of elevated cholesterol rose from 28.6 percent in 1999 to 38.9 percent in 2009. New York State has prioritized increasing access to high-quality preventive care and clinical management of heart disease, as well as addressing associated risk factors, including tobacco. These priorities are described in the chronic disease action plan that is part of the [New York State Prevention Agenda 2013](#), the state's health improvement plan.

NY CPHI is part of a national cardiac healthcare quality improvement (QI) initiative funded since August 2011 through the Centers for Medicare & Medicaid Services (CMS). The national CPHI aims to reduce major risk factors for heart disease and stroke (high blood pressure, high cholesterol, and smoking) by contracting with QIOs in each state to improve cardiac care management at the healthcare practice level.

OVERVIEW OF THE INITIATIVE

NY CPHI involves a variety of partners and key stakeholders at the state, regional, and local levels. State-level partners include NYSDOH and IPRO. Regional partners include Catholic Medical Partners. Community/practice-level partners include Southgate Medical Group and Northtowns Cardiology. Health IT partners include MEDENT. Each partner is described in more detail below.

State-level partners: NYSDOH and IPRO

NY CPHI uses the Improving Chronic Illness Care (ICIC) [Chronic Care Model](#) to provide technical assistance and support to individual practices to: enhance access and continuity of care; identify and manage practices' at-risk patient populations; plan, manage, and coordinate care; provide self-care support and community resources; and measure and improve performance around Million Hearts metrics, including the [ABCS](#) of heart disease and stroke prevention.⁵

Aim of the Integration:

By July 2014, reduce risk factors and improve health outcomes for patients with cardiovascular disease or at high risk of developing cardiovascular disease in approximately 150 primary care practices across New York State through improvements in the ABCS

IPRO received its CMS contract in August 2011. Shortly thereafter, NYSDOH contacted IPRO about collaborating through NY CPHI, since the initiative aligned with both partners' priorities and existing efforts to address hypertension in primary care settings. Key state-level activities to date include:

Steering Committee Establishment — IPRO and NYSDOH jointly identified [steering committee members](#), who include: primary care providers; health plans; advocacy groups; state and federal government agencies; and experts in hypertension control, health systems change, and QI. The committee provides guidance on NY CPHI's broad goals, supports IPRO in meeting its CMS statement of work requirements, and addresses the broader metrics of Million Hearts. The committee has:

- *Developed a [project charter](#)* — The charter includes NY CPHI's overall aim, desired outcomes, and strategies for achieving those outcomes.
- *Established metrics* — The project has established goals and metrics that primary care practices track and report through their electronic health records (EHRs). These include Million Hearts metrics, particularly around hypertension control. See the "Measurement and Accountability" section for more information.
- *Reviewed existing hypertension change packages* — The change package is a set of recommended systems-level changes for practices to test, implement, and spread to improve hypertension outcomes among their patients.

Practice Recruitment — IPRO and NYSDOH, with assistance from the steering committee, are collaborating to recruit more than 165 practices across the state to participate in NY CPHI. Because CMS has no formal requirements about the practices' specialties or compositions, the focus is on recruiting mostly primary care practices with an EHR system in place to facilitate data collection and follow-up.

Data Collection and Technical Assistance — IPRO is collecting de-identified patient data from the recruited practices' EHRs and provides training, technical assistance, and tools to assist them in implementing changes that improve cardiovascular care management and health outcomes, as well as expand focus to the policy level. Some of the key resources that have been, or will be, created or leveraged include:

- *EHR data analysis and online dashboard* — New York has many EHR vendors, and standardizing data across these systems is challenging. In addition, providers often don't recognize the value of looking at population-level data and frequently have difficulty extracting data from their EHRs to examine population-level metrics. IPRO provides technical assistance to the recruited practices to better enable them to analyze and report on the NY CPHI and Million Hearts metrics. IPRO is also establishing an [online dashboard](#) that compiles data from participating practices' EHRs. The dashboard will present the data in a format that will enable each practice to review data from its specific patient population and compare it with practices of similar size or geographic area (practices will not be identified on the website). The practices can also request specific training and technical assistance to improve care management and workflow redesign.
- *Trainings* — NYSDOH has connected IPRO with [MCD Public Health, Inc.](#) (MCDPH), a Maine-based company that has developed a blood pressure measurement train-the-trainer program. The program is designed to improve competency in proper blood pressure management technique among healthcare workers and anyone regularly taking blood pressures. It also trains them to

identify common blood pressure measurement errors and their cumulative effects, implement team-based care, and use QI approaches in participants' practices. IPRO has a contract with MCDPH, and the train-the-trainer sessions were held in fall 2013 among NY CPHI Steering Committee members, recruited practices, and IPRO and NYSDOH staff.

- *IPRO technical assistance products* — Through its role as a QIO, IPRO provides practices with many different QI services and products. Many of these services are being tailored through NY CPHI to focus on QI around hypertension control and better tracking of Million Hearts metrics at the patient population level. Key services in this area include training for patient self-management support, clinical decision support, patient-centered medical home support, data collection, facilitation of a Cardiac Learning and Action Network,⁶ and focused technical assistance.
- *Other existing resources* — In addition to the materials available through the national Million Hearts website, NY CPHI leverages existing resources from previous cardiovascular disease prevention initiatives, including: [resources to improve care using clinical decision support](#) developed with funding from the Office of the National Coordinator for Health IT; a [clinical decision support guide](#) from the Primary Care Development Corporation that uses hypertension as an example; a [training guide](#) and other [hypertension care QI tools](#) from the Community Health Care Association of New York State for practices to use in assessing their staffs' competency in blood pressure measurement; and resources related to NYSDOH's tobacco program [quitline](#), tobacco cessation centers, and QI work.

Health IT Partner: MEDENT

IPRO works with a variety of health IT partners across the state, particularly EHR vendors. One is MEDENT, a private company and major EHR vendor across the northeast region that is based in Auburn, New York. IPRO does not have a contract with MEDENT, but MEDENT contracts directly with practices, independent practice associations (IPAs), and accountable care organizations (ACOs). However, IPRO and MEDENT have a very strong, positive working relationship based on continuous interaction. IPRO and MEDENT work together to ensure that tools and reports that participating practices need are included in the MEDENT EHR system. MEDENT also provides direct technical assistance to the 55 practices participating in NY CPHI across the state that use the MEDENT EHR system.

Spotlight: Health IT

Effective and standardized use of EHR systems is critical to effective data collection and analysis at all levels of NY CPHI. The reports and tools that are generated from good EHR data are central to QI efforts around the ABCS.

Regional Healthcare Partner: Catholic Medical Partners

Catholic Medical Partners (CMP) is an IPA with more than 900 members across a three-county region in Western New York, including independent primary care physicians, pediatricians, and specialists, as well as the major hospital system in the region. CMP emphasizes and supports QI efforts among its members, as well as clinical integration, use of case managers, patient-centered medical homes (PCMHs), and partnering with health plans.

Since 2008, CMP has used EHR data for population health reporting and improvement within community practices. IPRO and CMP began working together in 2008 on registry development and medical reporting for preventive screening rates. CMP has licenses with two EHR vendors—one is MEDENT—and offers its members access to these systems at a reduced rate. In addition to employing in-house health IT staff that provide direct technical support to members in managing their health IT data, CMP also provides direct clinical support and infrastructure/systems change support to members to help improve quality of care. For example, CMP employs nurse educators that physically visit member practices and help them establish effective work flow design and steps to take if a patient with high blood pressure is identified.

CMP also has an office-based care coordination program to improve the delivery of medical care to patients with congestive heart failure, coronary artery disease, and diabetes. The program is funded through CMP's contracts with health plans and CMS, and staffs approximately 150 nurse care coordinators in participating offices. They provide care coordination services, including outreach and telephone follow-up, one-on-one education and disease management counseling, connecting patients to community resources, support for home blood pressure monitoring, and referrals to community services. CMP provides support to the care coordinators through a nurse educator who conducts site visits every 2-3 months to discuss challenges and new CMP resources.

When IPRO began work on the NY CPHI, its focus on improving blood pressure management complemented CMP's focus on QI. IPRO currently subcontracts with CMP to support implementing NY CPHI QI activities with its members. IPRO provides guidance to CMP on use of the ICIC Chronic Care Model for conducting QI, as well as specific measures to track, including blood pressure. CMP in turn interacts directly with its participating member practices to implement the QI initiatives most appropriate on a case by case basis.

Community Partner: Southgate Medical Group

Southgate Medical Group (SMG) is a primary care practice in Western New York. SMG serves more than 15,000 adult patients with a variety of insurance plans. It has 17 providers, including primary care physicians, physician assistants, and specialists, as well as ancillary services including a pharmacy, physical therapy, and coumadin clinic. SMG has been a member of CMP for seven years.

SMG has had the MEDENT EHR system in place for 10 years. As part of its QI work with CMP, SMG's QI staff and practice administrator recently reviewed data trends for its patient population and noticed its patients' blood pressure numbers were higher than other practices in the area. The practice administrator instituted some systems-level changes by training staff on new office blood pressure measurement protocols, including adjusting the timing of initial blood pressure checks after patients arrive and alerting physicians to do a recheck if the initial blood pressure reading is greater than 135/85.

SMG receives incentive funding from local HMOs (via CMP) based on how its blood pressure numbers rank compared to other practices in its area. Much of this funding is used to staff five care coordinators.

Community Partner: Northtowns Cardiology

Northtowns Cardiology (NC) is a full-service cardiology practice in Western New York. It provides a variety of services, including exercise stress testing, nuclear stress testing, stress echocardiography, resting echocardiography, Holter monitoring, EKG, ambulatory blood pressure monitoring, and a

coumadin clinic. The majority of NC patients are high-risk. For example, they have been diagnosed with coronary artery disease (CAD) or congestive heart failure (CHF) and have been referred to NC by their primary care providers.

NC is a CMP member and employs a CMP-funded registered nurse care coordinator, who uses a patient registry to identify patients at high risk for heart attack or stroke (particularly those with CAD and CHF) and provides care management services. NC uses the MEDENT EHR system, and the care coordinator leverages the system's reminder capabilities to follow up with individual patients as necessary.

Tools and Resources

Financial support for NY CPHI comes from IPRO's CMS contract. NYSDOH funded a QI consultant during the initiative's early stages using CDC chronic disease prevention grant funds. Other NYSDOH contributions include staff time supported by CDC chronic disease prevention grants and state funds. Other resources particularly useful for regional and community/practice-level partners include:

- Best practice guidelines and national practice standards related to hypertension management and control. These include the [Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure \(JNC7\)](#), [National Quality Forum \(NQF\)](#) measures, [Institute for Clinical Systems Improvement \(ICSI\)](#) guidelines, [Clinical Quality Measures](#), [Meaningful Use](#) criteria for use of EHRs, and [National Committee for Quality Assurance \(NCQA\) PCMH certification criteria](#).
- The [Stanford Chronic Disease Self-Management Program \(CDSMP\)](#) and the Stanford Diabetes Self-Management Program (DSMP), both in English and Spanish.
- *Living A Healthy Life With High Blood Pressure*: a supplementary self-management session to CDSMP and DSMP created by the University at Albany School of Social Welfare with input from IPRO and the NYSDOH. The session is offered in both English and Spanish.
- The Institute for Healthcare Improvement (IHI) Office Practices and Outpatient Settings- IHI IMPACT Collaborative Change Package.
- QI tools, including the Washington State Department of Health's "[Improving the Screening, Prevention, and Management of Hypertension – An Implementation Tool for Clinic Practice Teams.](#)"
- "[Hypertension in Diverse Populations: a New York State Medicaid Clinical Guidance Document](#)" from the New York State Medicaid Prescriber Education Program.
- Data management tools and resources (described in the "Measurement and Accountability" section).
- [Safety Net Medical Home Initiative](#) tools.
- EHR, health IT, and workflow optimization resources from the [NY eHealth Collaborative](#).
- Agency for Healthcare Research and Quality's [TeamSTEPPS Primary Care Version toolkit](#).
- CMS's [Physician Quality Reporting System \(PQRS\)](#) materials.
- [CMS EHR Incentive Programs](#).
- [Dartmouth Clinical Microsystems](#).

Additional resources and conditions necessary for continued success include:

- Additional/continued funding, either through federal sources or through payers/health plans at higher reimbursement rates.
- Technical expertise and assistance, both in health IT and blood pressure management.
- Better integration of health IT, such as better data transfer across EHR systems and more protected transfer of data between practices.
- Continued/growing support from providers for the care coordination model.

Next Steps

At the state level, longer-term goals for NY CPHI include broadening the steering committee membership base, expanding data collection capacity, honing data collection processes, and disseminating results.

Each regional and local partner has its own goals and next steps. For example, the NC care coordinator hopes to establish a practice-wide system that will allow her to shift her focus from just the highest-risk patients and address lower-risk patient groups with more focus on prevention.

Public Health Role

As a public health leader, the New York State Health Commissioner plays a critical role in supporting success of the NY CPHI by: connecting major NYSDOH initiatives and ensuring they include evidence-based strategies to improve blood pressure control; support state and local efforts for the primary prevention of hypertension by addressing obesity, physical activity, and reduced sodium consumption; sharing evidence-based strategies (for example, adopting hypertension treatment protocols, use of home blood pressure monitoring with support) with health system leaders; and working with national organizations and initiatives such as the NQF, NCQA, Institute of Medicine, and others to agree on core measures related to hypertension.

Spotlight: State Health Agency Role

- Working with IPRO, jointly established the NY CPHI Steering Committee.
- Provide strategic planning and support to the NY CPHI Steering Committee.
- Recruit practices.
- Provide access to training opportunities and technical assistance providers.
- Leverage network of chronic disease self-management programs.

NYSDOH key roles as a state health agency are described in the call-out box to the right, and include overall strategic guidance, connecting and convening key partners, and leveraging technical assistance resources. In addition, regional and local partners believe public health can play other important roles in supporting the QI work that is central to NY CPHI, including:

- Raise awareness among providers about the importance of looking at population-level data, as well as support the resources and technical assistance necessary to do so.
- Set the agenda on key population-level health indicators on which providers should focus, and leverage health IT to allow providers to track those indicators among their own patients.

- Communicate national guidelines and practice standards. For example, SMG received information from its local health department summarizing national standards and key algorithms for managing blood pressure and diabetes.
- Educate and raise awareness among the general public on the importance of blood pressure control and what normal blood pressure numbers are.
- Address barriers to blood pressure self-monitoring and blood pressure checks in the community.
- Support programs that reduce out-of-pocket expenses for blood pressure medications.
- Support team-based care and care coordination models, particularly among practices that serve high-need populations (for example, in community health clinics). These healthcare sites may need additional support and resources to connect patients to additional healthcare services.

MEASUREMENT and ACCOUNTABILITY

Performance Measures

Overall goals: The NY CPHI Project Charter identifies expected outcomes among participating practices, including: quarterly EHR data reporting; participation in Cardiac Learning and Action Networks; and 20 percent improvement over baseline for key performance indicators, including hypertension screening (PQRS 317), hypertension control (NQF 18⁷ and PQRS 236), documented aspirin use, LDL cholesterol screening, tobacco use screening among all patients, and tobacco cessation counseling when appropriate. Specifics are outlined in the [NY CPHI Core Measures](#).

At the state level, NYSDOH is also tracking progress on the indicators in the [Prevention Agenda: New York State's Health Improvement Plan](#), including objectives to increase the percentage of health plan members with hypertension who have controlled blood pressure and reduce the age-adjusted hospitalization rate for heart attack.

State Partner Measures: IPRO found that, in 2013, practices participating in NY CPHI are using different standards and measures to track and record blood pressure status. This lack of standardization has prevented IPRO from aggregating all practice site data. IPRO is working with participating practices to standardize reporting using NQF 18. IPRO also supports other blood pressure metrics, such as NQF 73 (ischemic vascular disease blood (IVD) pressure management).

Regional Partner Measures: CMP uses the (ICSI) guidelines for hypertension treatment and management (goal BP<140/90). CMP also tracks Meaningful Use criteria, NQF, and quality incentive program criteria that are negotiated with individual payers.

Community Partner Measures: SMG and NC both follow ICSI guidelines for blood pressure control. SMG also uses a grading system for blood pressure goals, cholesterol management, and HbA1c goals, using 90 percent control rates as a benchmark. NC also “coaches” high-risk patients (those with coronary artery disease or congestive heart failure) on the goal of BP <130/80.

Health IT/Data Management System and Tools:

MEDENT's EHR system is designed to meet Meaningful Use criteria. MEDENT Disease Management Reporting staff work directly with CMP and individual practices to develop a variety of tools. In addition, CMP contracts with MEDENT to collaboratively develop tools, and also has its own in-house health IT

staff that can work directly with members to help them generate the tools below as needed/requested. These tools include:

- *Registries*: CMP and MEDENT help practices develop registries—in the form of Excel spreadsheets—with data on specific groups within their patient populations (for example, uncontrolled hypertensive patients). CMP has helped members develop registries for CHF and CAD/IVD that include blood pressure control indicators, LDL control, and medications. These registries are used to generate the quarterly data reports described above, as well as reports and dashboards.
- *Reports*: MEDENT helps practices develop interactive, on-screen clinical reports that can be customized to focus on specific patient populations and allow practices to identify lists of individual patients for follow-up.
- *Dashboards*: MEDENT is beta testing dashboards that will show patient population-level data and trends over time.
- *Clinical decision support reminder systems*: these systems include a variety of tools built into EMR systems that provide care team members with patient-specific filters to help them provide optimal care. Tools included in these systems may include: computerized alerts and reminders to care providers and patients; clinical guidelines; condition-specific order sets; focused patient data reports and summaries; documentation templates; diagnostic support, and contextually relevant reference information.⁸

Reporting

At the state level, IPRO manages data collection and analysis for NY CPHI. IPRO will report practice site de-identified data to the NY CPHI Steering Committee via the online dashboard. Longer-term goals for data systems at the state level include expanding data collection capacity, honing data collection processes, and disseminating the results.

IPRO also receives quarterly data reports from participating practices and partners on indicators including aspirin use, blood pressure control, cholesterol control, and smoking status. IPRO aggregates data at the practice level and shares it with the practices to allow them to track progress over time and compare themselves with similar practices. The dashboards described earlier will also allow the practices to better visualize their data.

At the local/regional level, CMP requires its members to submit quarterly data reports on patients with conditions including diabetes, CAD, and CHF, as well as those receiving preventive screenings. The reports contain a variety of health measures based on the benchmark/standard each individual practice is using, including smoking status and cessation interventions, aspirin use, and blood pressure control. CMP then provides to its members with “[Quality Trending Data reports](#)” that track various health indicators, including the percent of patients with BP < 140/90, LDL cholesterol < 100, appropriate use of certain medications, HbA1c < 8, and preventive screening rates. It also provides members with [disease-specific reports](#) on patients with diabetes, CAD, IVD, or CHF, and those receiving preventive screenings. The data for these reports is pulled from the registries members provide to CMP.

Data-related Challenges/Needs:

The data addressing Million Hearts metrics and the ABCS from practices’ EHRs present a number of challenges, including technical issues related to data accuracy and reliability, lack of data standardization

across EHR systems, and lack of capacity to analyze EHR data at a patient population level. For example, because aspirin use often is not recorded consistently on medication records, recorded use rates may be much lower than actual rates. IPRO is working with sites to improve aspirin metric accuracy by addressing work flow, clinician documentation, medication lists to include various over the counter drug names, and data mapping.

OUTCOMES

Because NY CPHI is relatively new, there is insufficient data to determine to what extent participating practices are realizing improvements around care management for cardiovascular disease and hypertension control. However, early process-related successes include: effective practice recruitment without providing financial incentives; increased attention to cardiovascular health and hypertension among participating practices; and a strong, viable partnership between NYSDOH and IPRO that is based on mutual learning and active, engaged collaboration.

At the regional level, CMP has been successful in systematically receiving data on health indicators from its members. Across its membership, CMP has seen improved measures on aspirin use and blood pressure management. For example, at SMG, the percent of patients with blood pressure < 140/90 increased from 74.4 percent in the first quarter of 2012 to 84.5 percent in the first quarter of 2013.

KEY RECOMMENDATIONS

Key lessons learned and recommendations from NYSDOH and NY CPHI partners at all levels to date include:

- **Collaboratively define metrics.** Agreeing up front on how to define success and what metrics to track makes the data collection and analysis processes more efficient and reduces burden on practices.
- **Maintain longevity of focus and resources allocated to improve cardiovascular health.** Improving cardiovascular care at a systems level is a complex and time-intensive effort. Shifting focus and resource allocation at the national level does not support lasting, sustained change. Therefore, IPRO and NYSDOH encourage CMS to continue focusing attention and resources on cardiovascular disease management.
- **Identify and leverage a variety of partners.** Focus on public health-healthcare partnerships and partnerships with community entities and resources. Forming public health-healthcare partnerships results in a more robust initiative, able to leverage each partner's unique assets and resources. A proactive approach to establish partnerships is essential.
- **Build on existing initiatives.** Particularly in times of resource scarcity, building on the work of both public health and healthcare partners is key to maximizing impact.
- **Leverage team-based care and care coordination models to facilitate QI at the practice level.** Care coordinators can help overcome time barriers to QI and connect patients to resources. Focus on leveraging everyone in the office, from front office staff to providers, to work at the highest level to deliver high-quality care.
- **Leverage health IT.** Use EHR systems as much as possible to identify hypertensive patients. Take advantage of these systems' full capabilities (for example, by creating registries and meaningful reports) to look at individual and population-level data in the most useful way. Set up reminder systems and messages that can be shared among different healthcare team members.

- **Achieve buy-in from leadership at all levels.** Buy-in from leaders at every level, from the state health official to clinic leadership is essential. With individual practices, this includes getting buy-in from both physicians and operational staff. Leadership development sessions can help increase buy-in.
- **Engage payers to change reimbursement structures to prioritize hypertension management.** Other conditions such as CHF, renal failure, and reducing hospital readmissions are often perceived as higher priorities for payers. Engaging payers in discussions about payment models to encourage hypertension management will be critical for long-term sustainability of efforts.

INFRASTRUCTURE TO SUPPORT COLLABORATION AND SUSTAINABILITY

IPRO and NYSDOH have a long history of working together on chronic disease prevention projects. Although there is no formal written or financial arrangement between the two partner organizations, each understands the unique, complementary strengths and resources the other brings to the table for the NY CPHI effort. This allows the partnership to co-facilitate the NY CPHI Steering Committee in a structured, sustainable way.

Both NYSDOH and IPRO are interested in enhancing their existing partnership. NYSDOH provides connections to training opportunities and technical assistance providers, as well as its extensive network of chronic disease self-management programs, which IPRO leverages to access practices statewide. NYSDOH's ability to focus state-level community health priorities on specific topics, such as cardiovascular health, is a powerful leverage point. IPRO brings to the partnership its connections and relationships with clinical practices, expertise in EHR data collection and analysis, QI technical assistance, and general knowledge of the healthcare system. IPRO's network increases NYSDOH's reach among clinical practices.

Critical Supportive Factors

Federal-level factors that support ongoing success of this initiative include:

- Continued emphasis on alignment of Million Hearts measures with other metrics across quality improvement initiatives such as Meaningful Use, MAP, Clinical Quality Measures, and others.
- Support for evidence-based strategies in federal initiatives such as CMS Innovation Grants and State Health Improvement Plans, Prevention and Public Health Fund, QIO contracts, Agency for Community Living (formerly Administration on Aging), and others.
- Sharing with states PQRS data on hypertension control rates among Medicare patients. This is an important data set for New York because its Medicare patients have the highest hypertension prevalence rates.
- Continue to support sustainable funding mechanisms for community-based chronic disease self-management efforts.

State-level supportive factors include: The NYSDOH Commissioner's commitment to Million Hearts' goals and efforts to connect to other state initiatives; strong investment in NYS in Health IT; creation of an all-payer claims database; support for the [New York State Prevention Agenda](#), which sets goals for improvements in blood pressure control; the launch of [New York State of Health](#) (New York State's health benefits exchange); and continued state focus on supporting Meaningful Use and improving diabetes care, which includes a strong blood pressure management component.



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Practice-level conditions that support success include: achieving buy-in from all providers and administrative-level staff to establish a culture of high-quality, team-based care; an administrative-level champion that operationalizes team goals; and prioritizing and dedicating resources to QI (for example, hiring in-house QI staff).

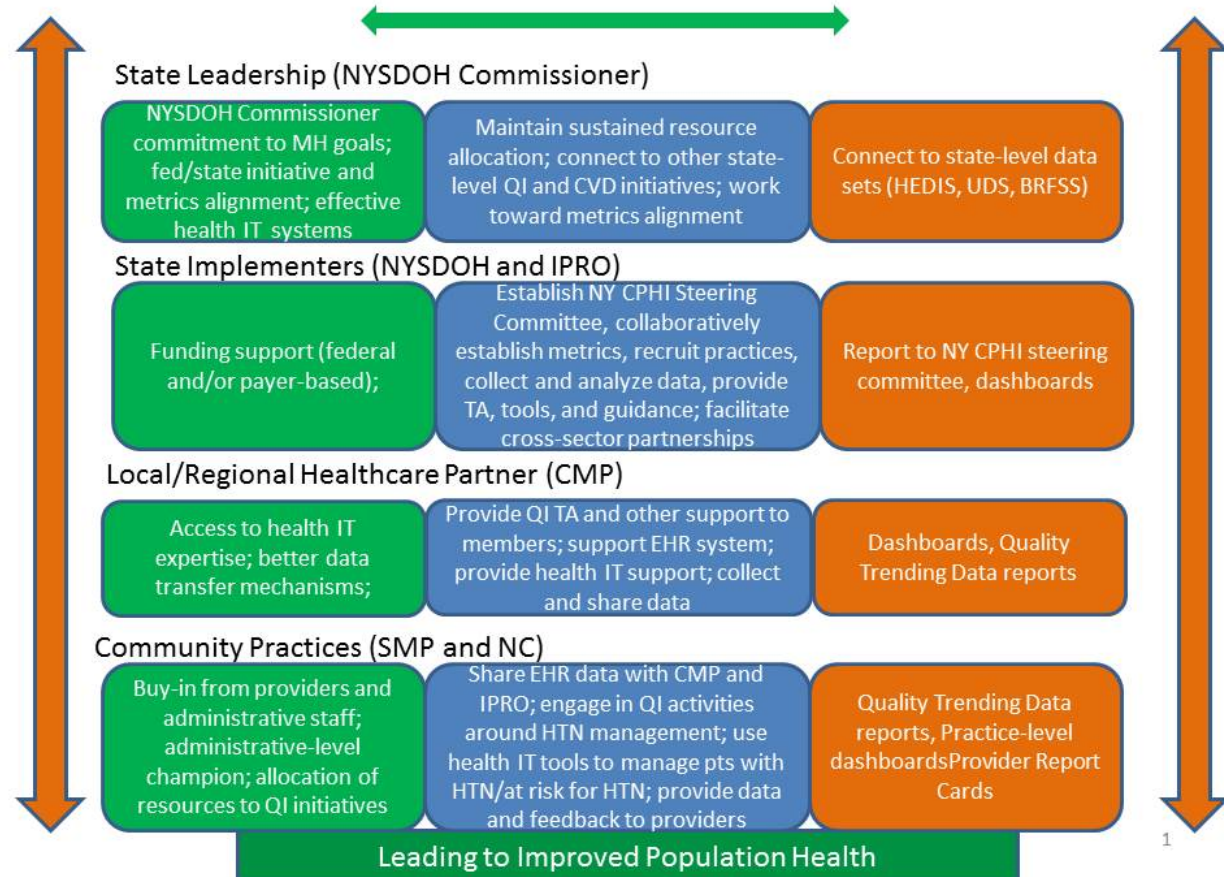
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Through-Line For NY CPHI



¹ QIOs are private, mostly nonprofit organizations that work to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries by reviewing medical care, helping beneficiaries with complaints about the quality of care, and implementing quality improvements throughout the spectrum of care. Source: Centers for Medicare and Medicaid Services. "Quality Improvement Organizations." Available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html?redirect=/qualityimprovementorgs>. Accessed 6-10-2013.

² The "ABCS" are: Aspirin therapy when appropriate, Blood pressure management, Cholesterol control, and Smoking cessation.

³ New York State Department of Health. "Cardiovascular Disease Mortality in New York State." Available at http://www.health.ny.gov/diseases/cardiovascular/heart_disease/docs/cvd_mortality.pdf. Accessed 6-10-2013.

⁴ CDC, National Center for Health Statistics. "Underlying Cause of Death 1999-2009 on CDC WONDER Online Database, released 2011." Available at <http://wonder.cdc.gov/wonder/help/ucd.html>. Accessed 6-13-2013.

⁵ NY CPHI Charter. Unpublished.

⁶ "Learning and Action Networks" are facilitated by IPRO through its CMS contract and serve as information hubs for learning, collaborating and elevating the voice of the patient, with a goal of improving care delivery and patient outcomes. Source: IPRO. "Learning and Action Networks." Available at <http://www.ipro.org/index/lan>. Accessed 6-17-2013.

⁷ National Quality Forum (NQF) Measure 18 is defined as "The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year." Source: National Quality Forum. "Measures, Reports, and Tools." Available at <http://www.qualityforum.org>. Accessed 1-29-2014.

⁸ DHHS, Office of the National Coordinator for Health Information Technology. "Clinical Decision Support." Available at <http://www.healthit.gov/policy-researchers-implementers/clinical-decision-support-cds>. Accessed 1-29-2014.