

Heart Health Now!

The North Carolina Cooperative for AHRQ's EvidenceNoV

Advancing Heart Health in Primary Care









Funded by the Agency for Healthcare Research and Quality (AHRQ) in the U.S. Department of Health & Human Services

Heart Health NOW NC Population Data

- Cardiovascular Death Rate 263 per 100K
 -1/3 of all NC deaths (32nd in U.S.)
- Annual cost: \$4.6 billion dollars (inpatient alone)

Risk Factors

- 65% obese / overweight
- 54% lack physical activity
- 40% high cholesterol

- 32% HTN
- 10% diabetic
- 20% smoke

Heart Health NOW Advancing Heart Health in NC Primary Care

Why NOW?.... Getting Heart Health Right in NC

- Fulfill the Promise of Primary Care
 - Prevent chronic disease from advancing to serious illness
 - Reduce patient suffering
- Join with Selected Primary Care Practices
 - Build systems of care
 - Decrease risk of cardiovascular events and death

Heart Health NOW Overview

Who Is Eligible?

 Primary Care Practices: Have an EMR, ≤10 Providers / site & serving adults, CA II or participating in Medicaid MU. Selecting 250-300 practices in NC.

Time Frame

3 Years

Partners for Success

- UNC Chapel Hill, Cecil G. Sheps Center for Health Services Research
- Community Care of North Carolina (CCNC)
- NC Area Health Education Centers Program (NC AHEC)
- NC Healthcare Quality Alliance

Heart Health NOW Heart Health NOW Cardiovascular measures

- 1. Ischemic Vascular disease (IVD): Use of Aspirin or another Antithrombotic (PQRS 204/NQF 0068).
- 2. Aspirin for the Primary Prevention of Cardiovascular Disease **
- 3. Blood Pressure Management: Controlling High Blood Pressure (<140/90) (PQRS 236/NQF 0018)
- 4. Blood Pressure Management: Controlling High Blood (JNC8) **
- 5. Tobacco Use Screening (PQRS 226 Part A modified) / NQF 0028
- 6. Smoking Cessation Support (PQRS 226 Part B modified) / NQF 0028
- 7. Statin Therapy for Prevention and Treatment of Cardiovascular Disease ** (proposed CMS eMeasure)
- 8. Risk Based Statin Therapy**
- 9. Assessment of Cardiovascular Risk **
- ** Novel measure developed with UNC expert panel

Heart Health NOW Study Evaluation – The Outcomes

ABCS measures for all patients (not just Medicaid).
 These are outematically pulled from your EMD exetem.

These are automatically pulled from your EMR system – no extra clicks or manual entry necessary

- ASCVD (ACC/AHA) Risk Calculus
- Surveys Baseline, Immediately After Practice Facilitation, Post intervention
- Exploratory Data on Utilization, Mortality, Cost
- The Secret Sauce of Implementation

Heart Health NOW Reduce CVD Risk

We can make an IMPACT!!!

To Improve Patient Health

Control 1 or 2 Measures:

Can reduce short-term event risk



Control ALL Measures:

Can reduce lifetime CVD mortality risk /



Heart Health NOW

Benefits – To Your Practice (QI and Informatics Support)

- Onsite practice coaching and informatics support for your practice to:
 - Implement evidence-based practices for CVD prevention
 - Optimize use of EHR to prepare for value-based payment
 - Facilitate effectiveness and efficiency:
 - Resource utilization
 - Billing, coding
 - Patient self-management support
 - Closing the referral loop
 - Patient and staff satisfaction

Heart Health NOW Benefits – To YOU for Educational Opportunities

- Interaction with national and regional content experts
 - New clinical guideline recommendations
 - Evidence-based practices for CVD prevention, including:
 - CVD risk assessment calculator
- Multiple formats:
 - Webinars
 - Regional meetings mini collaboratives
 - Onsite practice consultations
 - CME and other CE credits available.
 - Counts for MOC Part IV (QI project)

Heart Health NOW Benefits – Patient Population Management

- Access to CCNC's Informatics Center (IC)
 - Heart Health Now NC Dashboard CVD Measures
 - Patient registries & longitudinal records
 - Clinical Quality Measures (eCQM) application
- Dashboards compliment current practice initiatives, including:
 - Meaningful Use (MU)
 - Patient Centered Medical Home (PCMH)

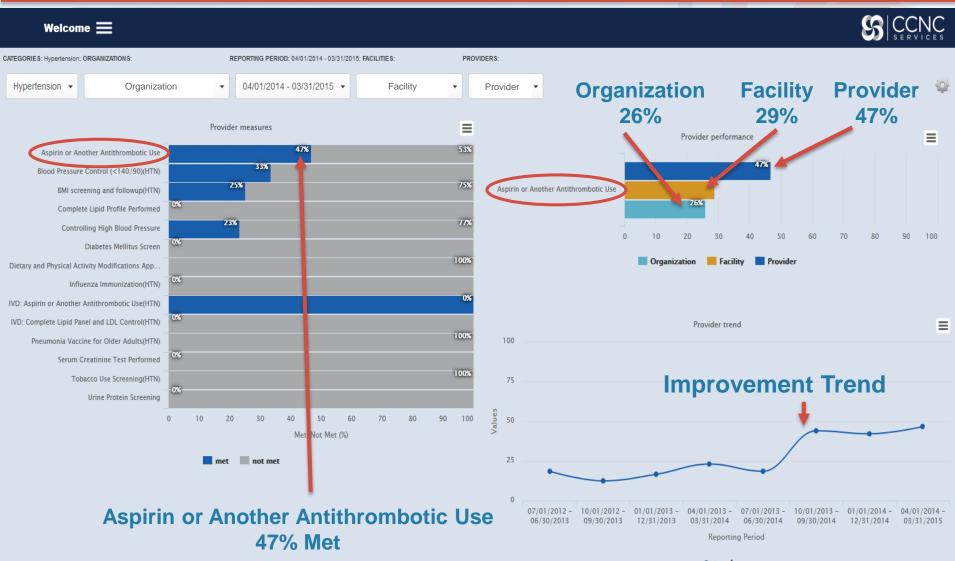
Heart Health NOW Benefits – To Your Practice (Financial)

Fees associated with NC HIE/ CCNC Integration:

- 1. Integration (connection of EMR to NC HIE/CCNC's IC) state subsidy is currently still available
- 2. Maintenance fee HHN grant can cover some/all of these fees
- **3. User Subscription fee** \$175/physician/ year (All other users are free). The grant does NOT cover this fee.
- Heart Health Now grant will pay for certain of these fees from the date the practice signs MOU through April 30, 2018.
 - Your practice will also receive remuneration for all surveys and interviews completed during the project.

** Work with your Practice Facilitator (contact info on last page) to help calculate the financial benefits for your particular situation.

Heart Health NOW Dashboard – Organization, Facility and Provider View

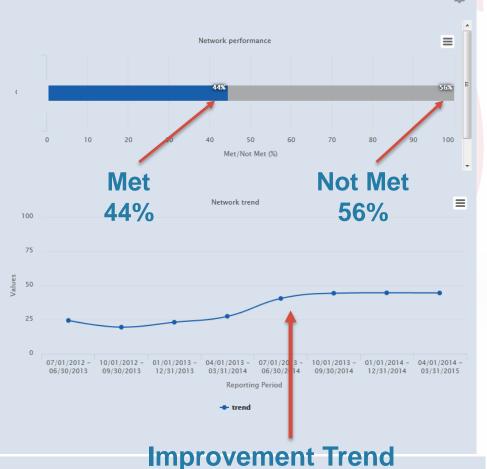


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Heart Health NOW Dashboard – Organizational Performance View

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/ Seled	tall × Selectnone]	Eligible			
Type he	ere to search X	\$	Patients %	<u>Period %</u> ÷	<u>Goal %</u>	÷
Asthma	a	ic Use	9,692	16	80	Â
Diabete	-		_	59	80	
Hypert MU1	ension	eart Health N	ow	16	80	
Pediatr	ric Preventive Care	:d	10,830	62	80	
•		;	15,212	37	80	
0	Diabetes Mellitus Screen		10,796	53	80	
0	Dietary and Physical Activity I	Nodifications Appropriately Prescribed	10,796	0	80	E
0	Influenza Immunization(HTN)		6,336	36	80	
•	myocar infarction (AMI), coronary coronary interventions (PCI) in the 12 had an active diagnosis of ischemic v	ithrombotic Use(HTN) and older who were discharged alive for acute artery bypass graft (CABG) or percutaneous months prior to the measurement period, or who ascular disease (IVD) during the measurement use of aspirin or another antithrombotic during the	557	44	80	
	IVD: Complete Lipid Panel an	d LDL Control(HTN)	557	45	80	
0	Pneumonia Vaccine fur Older	Adults(HTN)	3,480	0	80	
•	Serum Creatinine Test Perior	med	10,796	75	80	
0	Tobacco Use Screening(HTN)		10,057	0	80	Ŧ

Welcome 📃



SS CCNC

Aspirin or Another Antithrombotic Use

Heart Health NOW Dashboard – Single Facility Performance View

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CATEGO	RIES: ORGANIZATIONS: REPORTING PERIOD: 04/01/2014 - 03/31/201	5; FACILITIES:			PROVIDERS:
	 ▼ 04/01/2014 - 03/31/2015 ▼ 		•	•	
÷	<u>Measure</u>	<u>Eligible</u> <u>Patients %</u>	<u>Period %</u> ÷	<u>Goal %</u> ≑	Provider 1
•	Blood Pressure Control (<140/90)(DM) Percentage of patients aged 18 through 90 years old with a diagnosis of diabetes whose	584	56	80	Provider 2 62% 38%
	mos recent blood pressure was under control (< 140/90 mmHg)				Provider 3 44% 56%
0	BMI screening and followup(DM)	589	14	80	Provider 4
0	Eye Exam	505	0	80	Provider 5
0	Foot Exam	505	2	80	Provider 6 0 10 20 30 40 50 60 70 80 90 100
0	HbA1c Control (<8.%)	505	42	80	Practice trend Met/Not Met (%)
0	HbA1c Poor Control (>9.0%)	505	47	80	100 met int met
0	HbA1c Test Performed	505	76	80	75
0	Influenza Immunization(DM)	324	18	80	
0	IVD: Aspirin or Another Antithrombour Use(DM)	22	5	80	50 values
0	IVD: Complete Lipid Panel and LDL Cont ol(DM)	22	14	80	25
0	LDL Control (<100)	505	18	80	0 07/01/2012 - 10/01/2012 - 01/01/2013 - 04/01/2013 - 07/01/2014 - 10/01/2013 - 01/01/2014 - 04/01/2014 -
0	LDL Test Performed	505	40	80	06/30/2013 09/30/2013 12/31/2013 03/31/2014 06/30/201 09/30/2014 12/31/2014 03/31/2015 Reporting Period
0	Tobacco Use Screening(DM) BP Control	584	0	80	- trend
0	Urine Protein Screening(DM) 31% Met	580	92	80	Improvement Trend

Heart Health NOW Dashboard – Patient Longitudinal View

≡	Welcome								S CCNC
<u> </u>	Search for a patient	Ø	Rx	Labs (LD	L-C)	Blood Pres	ssure	DOB:	
> Pro	oblem List				• Care	Guidelines			0
	Problem		ICD Date Code [♦] Identifie	ed ^{\$} Source	Category		+ Most Recent :	¢ Date ¢	Source 🗢
EMR			V88.01 09/24/20		Diabetes	Blood Pressure	147/82	9/24/2014	BCRHA - Lewiston
EMR			401.1 09/24/20	114 BCRHA - Lewiston	Diabetes	BMI calculation	45.24	9/24/2014	BCRHA - Lewiston
EMR	DMII wo cmp nt st uncntr		250.00 09/24/20	BCRHA - Lewiston	Diebetes	Diabetes Eye Exam		9/24/2014	BCRHA - Lewiston
EMR	Mixed hyperlipidemia		272.2 09/24/20	BCRHA - Lewiston	Diabeter	Influenza Vaccination		9/24/2014	BCRHA - Lewiston
EMR	Screen mammogram NEC		V76.12 09/24/20	BCRHA - Lewiston		\backslash			
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	Vitals 🗢	Most Recent		♦ Source	÷ .	Labs		eference Range 🕈 Date	
		45.24	09/24/2014	BCRHA - Lewiston		Chloride	105 (mmol/L)	9/9/2013	BCRHA - Lewiston
		82 mm/Hg	09/24/2014	BCRHA - Lewiston		Cholesterol	246 (mg/dL)	9/9/2013	BCRHA - Lewiston
EMR		147 mm/Hg	09/24/2014	BCRHA - Lewiston		Cholesterol.in HDL	87 (mg/dL)	9/9/2013	BCRHA - Lewiston
EMR		63 255.4	09/24/2014	BCRHA - Lewiston BCRHA - Lewiston	EMR	Cholesterol.in LDL	147 (mg/dL)	9/9/2013	BCRHA - Lewiston
÷	weight	200.4	03/24/2014	DOKINA - LEWISTON		Cholesterol.in VLDL	12 (mg/dL)	9/9/2013	BCRHA - Lewiston
					-				•
> Act	Active medication st Image: Allergies and Adverse Reactions								
	Medication 🔶 SIG	≑ Qty ≑	Date Prescribed 🗢	Last Fill 💠 Source	¢ A	lergen	♦ Reaction ♦	Last Reviewed \$	Source 🗢

EMR

Heart Health NOW Timeline

- Practice sign up begins in Summer 2015
- Connection to CCNC Informatics Center (IC) Platform in Summer 2015 through Summer 2016
- Practice receives 12 months intervention support
 - Assigned start date for initiating practice intervention
 - Earliest start date in January 2016 & latest in summer 2016
 - Practice cohorts of 50, staggered every 2 months
- Data collection:
 - Before, during and end of intervention
 - 6 & 12 month follow-up

Heart Health NOW Participation

Step 1: Sign up with CCNC's Practice Facilitator (PF)

- Sign a Technical Agreement for EHR integration with CCNC IC or amend existing agreement.
- Sign a consent form to participate in study

Step 2: Complete 2 assessments measuring technical and quality improvement (QI) "readiness"

 Choose a provider champion and practice staff to complete study surveys with assistance provided by the CCNC PF

Step 3: Clinically integrate EHR with CCNC's IC (if not already integrated)

 Engage with the CCNC PF who will facilitate process to ensure baseline data can be established and data collected

Heart Health NOW Participation

Step 4: Receive training from the CCNC PF on the use of patient registries, dashboards and/or other IC tools.

Step 5: Engage with an AHEC Coach during the 12-month intervention period

- Receive on-site, individualized support from an AHEC coach assigned specifically to your practice
- Help the AHEC coach get to know your practice and how you and your staff like to operate, and what you want to improve
- Use patient registries, dashboards and/or other IC tools to drive the changes you want to make happen in your practice
- Learn from your AHEC coach what other practices have done to improve their care of patients with CVD
- Use the AHEC coach to better understand how this work prepares your practice for national and statewide payment programs

Heart Health NOW Learn More...

- To learn more about Heart Health NOW or if your practice would like to participate, please contact:
- Eastern NC: Jill Boesel at jboesel@n3cn.org or 919-516-8114 CCLCF and CCPEC network practices
- Western NC: Kerry Kribbs at <u>kkribbs@n3cn.org</u> or 919-926-3979 CCHP, CHP, CCofSP, CCPGM, CCWNC, P4CC and NWCC network practices NWCC and P4CC - Joy Key at <u>jkey@nwcommunitycare.org</u> or 336-716-3086
- Central NC: Robin Wagner at <u>rwagner@n3cn.org</u> or 919-745-2423
 4C, NP, CC Sandhills and CCWJC network practices

NC PATH and Central - Patrick Garrett at pgarrett@n3cn.org or 919-882-0321









Heart Health NOW Learn More...

NC AHEC REC Contact:

Monique Mackey, MLS

 Quality Improvement Manager
 NC AHEC Practice Support Program
 <u>monique.mackey@arealahec.org</u>







