In this issue of the NYC REACH Newsletter, we share stories about NYC REACH members who transformed their clinical and business practices to improve patient care through quality improvement programs.

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The Million Hearts® Hypertension Control Challenge is a nationwide competition to identify providers that have achieved an average hypertension control rate of at least 80% through innovations in health information technology, patient communication, and team-based care. The competition is part of the Million Hearts® initiative to promote heart health and reduce heart disease and stroke. The initiative is co-led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services (CMS). Learn more about Million Hearts® here.

NYC REACH is pleased to share that for the second year in a row, the Million Hearts® Hypertension Control Champions from New York City are NYC REACH members who participated in HealthyHearts NYC, an initiative to ensure primary care practices have the tools they need to adopt the ABCS of heart health: Aspirin in high-risk individuals, Blood pressure control, Cholesterol management, and Smoking cessation. The program was a three-year collaboration between the Primary Care Information Project (PCIP), the New York University School of Medicine, and the Community Health Care Association of New York State. NYC REACH continues to provide customized quality improvement support to help primary

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care practices achieve their hypertension control goals.

This year’s Hypertension Control Champions (and NYC REACH members), were among just 18 private practices and community health centers recognized nationwide.

**Dr. Jia Hong (Hong Jia Medical PC)** is an internist in Flushing, Queens. Dr. Hong takes a team-based approach to care for patients with hypertension. She also believes in the importance of communication, follow-up, and education. Patient education is a part of every care plan and each patient prescribed a new blood pressure-lowering medication receives a follow-up phone call.

*Visit page 4 to read our interview with Dr. Jia Hong about her approach to treating patients with hypertension.*

**Dr. Terence Hsuih (Eighth Avenue Medical Office)** is an internist in Sunset Park, Brooklyn. Dr. Hsuih’s hypertension control protocol starts with making sure blood pressure is measured accurately. The practice calls patients with newly prescribed blood pressure-lowering medication to discuss any potential side effects or concerns, and schedules each patient for a two-week follow-up appointment after starting the new medication.

**Dr. Himanshu Patel** and **Dr. Jigar Patel (Patel Medical Center)** are internists in Brooklyn. To ensure patients with hypertension receive appropriate follow-up care, practice staff schedule follow-up visits before patients leave the office. Staff also run monthly registries in their electronic health record (EHR) to identify patients with uncontrolled high blood pressure, then contact those patients to provide additional support and schedule appointments for those who have fallen out of care.

**Dr. Shelly Shi (Shelly Shi Medical PC)** is an internist in Chinatown. Dr. Shi and her staff use their EHR as a tool for optimizing care for patients with hypertension. They use the EHR to easily communicate with patients, and patients use it to schedule their own appointments. Dr. Shi also uses the EHR to assess and monitor medication adherence.

**Dr. Mark Tsinker (Bay Parkway Medical PC)** is an internist in Brooklyn. Dr. Tsinker believes in integrating behavioral health with primary care. When treating patients with hypertension, he considers behavioral health issues such as anxiety or depression that could be contributing to their high blood pressure. He aims to make medicine easier for patients to understand by offering patient education, and to make care more accessible by making house calls to patients who are unable to visit the office.

*Click here to read about the NYC REACH members who were recognized as Hypertension Control Champions in 2017.*
Q&A with Dr. Jia Hong, Hypertension Control Champion

Jia Hong is a family physician in Flushing, Queens. She sees about 3,000 patients a year, most of whom are newly-arrived Chinese immigrants. The most common conditions her patients have are high blood pressure, diabetes, overweight, and high cholesterol. Dr. Hong’s focus on managing high blood pressure led to a hypertension control rate of 82% among her patients, which made her a 2018 Million Hearts® Hypertension Control Champion! We spoke with Dr. Hong about her approach to patient care and hypertension management.

How did participating in HealthyHearts NYC change your practice?

The program increased our practice’s general awareness of the importance of blood pressure control. Now the staff all know how important it is. I truly believed if we implemented some new methods, we could improve quality measures on blood pressure control, and NYC REACH worked with us to come up with new ideas. And I’ll say ten times: thank you NYC REACH for bringing us to the national level! We were very excited about that. NYC REACH always lets us know what’s new, what’s coming along, what’s the next program. It’s really helpful to have someone come in and remind us of all the stuff we have to do. So thank you for all the effort!

How do you approach in-office visits with patients with hypertension?

One thing we did is come up with our own “logs” for patients. We have a blood sugar log and a blood pressure log. It’s this small piece of paper. They have to write down their blood pressure measure and bring it back in one week or two weeks.

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If it’s not controlled then they have to see me and I will review and adjust medication with the patient. If it’s good, we usually double check in the office to make sure it is good. It takes the whole team working together. Everybody checks it. And I can tell [patients] look, here’s how you take your medication, you need to exercise, change your diet.

I prescribe all of them blood pressure machines so they can check their blood pressure at home. I tell them to bring it to the office to show me how they use it. Sometimes they say it’s good at home, but they might not be taking it properly. We really want to make sure they can check it on their own correctly. There are a lot of small tricks to make patients understand how to do it. When you explain it to them they actually really appreciate it. They appreciate the effort and they know I care about them.

**What is your approach to patient education?**

We put a lot of emphasis on it. I do talk to the patients a lot. I truly believe it’s important for quality improvement. My belief is every visit is an opportunity for preventive care.

I think about one of three adults probably has high blood pressure and is undiagnosed. Some patients come to our office and they don’t know because they don’t have symptoms. I’ll talk to them and hand out a small piece of paper with hypertension control/diet/exercise/blood pressure goal. I emphasize complications if blood pressure is not treated - risk for heart attack and stroke, which they may not realize.

**What role do office staff play in treating patients?**

Team involvement is obviously really the key. I think it’s important for physicians to know that when we educate the front desk, everybody is more aware of patient needs and the quality improvement goal and it makes the physician’s job much, much easier. It is impossible to be done without the teamwork.

The important thing is right now, with a lot of quality measures, it’s not dependent on the physician only. And you save healthcare expenses by doing all these quality measures. Patients could be here for multiple medical problems: gastric issues, a rash here, a pain there, and I might not remember to check everything - whether they have any missing quality measures or not! So every visit the medical assistant will check if appropriate preventive care was done and documented in the chart, such as colonoscopy, mammogram, pap smear, eye exam, and more. If they say “Oh I saw the eye doctor already,” but we don’t have the consult, we will request a consultation report right away.

Everybody knows how to explain to patients “Here’s your goal, what you need to do.” I think that’s the most important.

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For example I have a sheet in the nurse’s station that breaks it down by age: according to their age, here’s what patients need to do (like a mammo or colonoscopy).

**How else do you review quality measures?**

We like the NYC REACH dashboards; I read those to check on the percentage rates of different conditions. We pull reports from our own EHR as well to catch up on care gaps. The EHR registry function can analyze a patient’s data and give us a care gap list. Whenever the flow of patients is slow, that’s our time to catch up. In summer we review CIR immunization records, call patients for missing immunizations.

**How do you encourage medication adherence?**

Sometimes I prescribe something and the patient says “Ok, the doctor ordered it, so I’ll do it.” But sometimes they’ll say, “Ok I checked my blood sugar and its low, then I’ll take half a pill. I’ll take more if it’s high tomorrow.” They do their own thing at home. I will tell patients, “If your meal plan is good, and you take this pill, you don’t have to check it every day. But if you ate something sweet today, tomorrow your blood sugar is going to be high.”

I’ll write down the medications for them in their language so they can understand better. It makes it easier for them to fill prescriptions and makes my life much, much easier as well. With the elderly, sometimes their medication is all over the place. I have them bring back all their medications for every appointment so we can check. And I take the time to explain why they need to take them.

**What’s your strategy for getting patients to change their lifestyle?**

It’s very important to give them a goal. I’ll talk to them about diet and exercise, what doctor they need to see next. Every sick visit we discuss smoking cessation if the patient is still smoking. I think it’s very important to have goals because it gets them involved.

**How do you keep in touch with patients?**

Once a patient is diagnosed with hypertension, we schedule a follow-up appointment in one or two weeks and put a reminder on our calendar to call them. A lot of the patients don’t understand emails from our EHR because they’re in English, so it’s best to just call. For the patients who speak English, I tell them to sign up for the patient portal! Sometimes if they don’t come we’ll send them a letter to make sure they need to follow up. We also use the dashboard reports to keep up with anyone who is not coming to the office. Whatever works to get them to follow up.
From 2016 to 2019, the Centers for Medicare & Medicaid Services (CMS) invested in local healthcare organizations to provide practice transformation support for a range of practice types through the Transforming Clinical Practice Initiative (TCPI). With the support of TCPI, NYC REACH worked with Federally Qualified Health Centers, hospitals, primary care providers, and specialists to maximize practice revenue, optimize patient care and care coordination, and share best practices from other providers.

The program organized participating clinicians around the country into Practice Transformation Networks (PTNs), resource-rich networks that provided practices and NYC REACH with new information on best practices. NYC REACH facilitated participation in two networks: the New York State Practice Transformation Network and the Greater New York City Practice Transformation Network.

Through the program, providers optimized clinical and business practices to meet their unique needs. Small practices increased their level of preparedness for value-based payment arrangements. Large health systems demonstrated significant cost savings, a decrease in duplicative services, and fewer gaps in patient care. Specialists, including behavioral health providers, updated workflows to close referral loops and prepare for value-based payment, and improved relationships with primary care providers.

The program comes to a close this year. However, NYC REACH continues to help practices achieve the same goals through its services for NYC REACH members. To learn more about how NYC REACH can support your practice, contact pcip@health.nyc.gov.

Visit page 8 to read about how the program helped to transform patient care at Crown Medical.
Crown Medical is an adult internal medicine practice in Crown Heights, Brooklyn. The practice has three doctors, two physician assistants, two registered dieticians, and two registered nurses. Most of the practices’ patients (about 9,000 seen per year) are on Medicaid and are members of the Chabad-Lubavitch community.

Crown Medical has been recognized as an “exemplary” practice by the New York State Practice Transformation Network for its success in the Transforming Clinical Practice Initiative (TCPI). Although the initiative is coming to a close this year, Crown Medical continues participation in other quality improvement programs with shared goals. We review below how Crown Medical has transformed patient care through these programs, with support from NYC REACH.

**Value-Based Payment**

The key goal of TCPI was to prepare providers for value-based payment (VBP) arrangements, in which providers are incentivized to lower patient costs. Through TCPI, Crown Medical developed a new approach to patient cost evaluation. The practice found that patients were accessing far more ancillary services (lab testing, imaging, medical equipment) than the national average. They also noticed high patient costs in evaluation and management services charged to other providers, which led the practice to focus more on care coordination. The practice now thinks beyond the costs of seeing patients in office to the costs of patients using a number of different services. Cost assessment and reduction is now part of the practice’s VBP strategy.

Another way the practice keeps total cost of care down is through out of office care. Home visits have always been a part of the practice’s culture. In case of an emergency, the practice has a volunteer ambulance service bring patients directly to the practice or chief physician’s home before using emergency department services.

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Medical Home Operations

The practice aims to be a patient-centered medical home in every sense of the term; putting patients first in every clinical and business decision. Dr. Eli Rosen, the practice’s founder, feels it is his mission in life to be a “village doctor,” a reliable source of care for the whole neighborhood.

The practice maintains New York State Patient-Centered Medical Home (NYS PCMH) Recognition, and has found that participating in the program helped to improve quality metrics and prepare the practice for success in the VBP landscape. The practice is able to hire staff to perform care coordination activities by consistently implementing NYS PCMH principles and meeting Healthcare Effectiveness Data and Information Set (HEDIS) measures.

New Revenue Streams

Crown operates a robust Medicare Chronic Care Management (MCCM) program, which allows the practice to provide extensive reimbursed care coordination services to older patients with multiple chronic conditions. The practice supports about 300 elderly patients per month, monitoring their chronic conditions and coordinating care with numerous specialists.

Quality Improvement

The practice designs quality improvement projects to meet Merit-Based Incentive Payment System measures and other program goals. Through the HealthyHearts NYC program, for example, the practice started using a new tobacco screening form and raised its screening rate from 80% to 97% in one year.

The practice is currently piloting a new patient activation measurement (PAM) tool with chronic care management patients. This tool helps practice staff assess a patient’s level of engagement and health literacy. Providers can design targeted interventions based on this assessment and use the tool to track improvements in patient activation in a structured format.

Keys to Success

The practice credits its success with two things. First, a mission-driven, patient-centric culture, and second, a willingness to try new programs and tools. Their advice to other practices? Be open to new programs. Find out what government programs may be offered in your area, and seek out new revenue streams.
Some of the most challenging activities in the NY Medicaid EHR Incentive Program involve health information exchange (HIE), patient portal usage, and public health reporting. Read below for tips and strategies implemented by NYC REACH members to meet these program requirements.

Dr. Sabina Awwal of Hillside Medical Care excelled in meeting requirements related to patient portal access and HIE during a 90-day electronic health record (EHR) reporting period in 2018. Dr. Awwal provided timely online health information access to 92% of patients and ensured 16% of patients viewed, downloaded, or transmitted their health information. For 74% of outgoing transitions of care, she used her EHR to transmit summaries of care to a receiving provider.

Health Information Exchange Tip: Work with external partners.

Identify your most common external partners and target them for HIE. This saves staff time spent faxing or otherwise sending referral documentation. How to do this:

- Run a report to identify the health networks and providers the organization refers to most frequently.
- Identify the best method to exchange information. This may depend on both providers’ EHR systems. The best method may be a health information service provider (HISP), a HISP connected to the EHR, or a feature built into the EHR.
- Obtain direct addresses or other contact information from receiving providers.
- Test the process! Send a referral to a provider and follow up via phone or regular email to ensure the practice received it. Request they do the same.

Dr. Awwal asked her staff to figure out which of her colleagues use the same electronic health record (eClinicalWorks) so they could work together to optimize its functionality. “My staff contacted them to explain how P2P works, and why they should use it,” she noted. “After those conversations, their staff activated P2P and we started sending each other referrals easily.”

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Tip on Patient Portal Usage: Assist patients in the waiting room.

- At each visit, ask if the patient has logged into the patient portal. If not, help them to log in and explain how to use it. If possible, show them specific features, such as where to find their immunization history.

- While the patient is waiting, ask them to sign into the kiosk or tablet to update their information, or just to make sure their username and password work. If no kiosk is available, suggest the patient use their smartphone.

- Provide Wi-Fi in the waiting room if possible.

- Explain that educational materials in the waiting room are also on the portal.

Dr. Awwal assigned staff to speak to patients about the portal. “The staff have a separate laptop they use to log patients in,” she explained. It’s a tedious process, but the only way we could reach the measure. We talked to their families in the waiting room too, and if they were patients as well, we had them log in to their own accounts.”

Public Health Reporting Tip: Choose an appropriate registry.

- When seeking outside registries, check for one that has made a public declaration of readiness before the first day of the provider’s EHR reporting period.

- Check with specialty societies to see if they have lists of appropriate registries available.

- Refer to the CMS Centralized Registry Repository for a list. However, note that registries on this list have not been vetted for program compliance.

- If no registry is available, save dated correspondence or documentation as proof of exclusion for audit preparation.

Tip on EHR Functionality: Run an EHR “system check.”

Providers sometimes find the features they assume are activated in their EHR have not been activated yet, or were deactivated during an upgrade. Complete a “system check” to make sure everything is functioning properly.

- Confirm that all electronic clinical quality measures (eCQMs) are set up correctly in the Meaningful Use dashboard report.

- Check other important features such as Rx eligibility check, drug interaction check, and the clinical decision support system.

- Make sure the EHR’s application programming interface (API) is activated. Once confirmed, take a screenshot with the date and time and save it for your records. Providers must activate this feature to meet program requirements, although patients are not required to use it.

- If your practice is new to using APIs, contact your EHR vendor for guidance.
ABOUT NYC REACH

The New York City Regional Electronic Adoption Center for Health (NYC REACH) is New York City’s Regional Extension Center, a designation of the U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology.

NYC REACH assists New York City-based independently owned private practices, community health centers, and hospital-based ambulatory sites with adopting and implementing health information systems and participating in quality improvement, and practice transformation initiatives.

NYC REACH is operated by the Primary Care Information Project (PCIP), a bureau in the Division of Prevention and Primary Care at the New York City Department of Health and Mental Hygiene.

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