NYC REACH

Regional Electronic Adoption Center for Health

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How neighborhood pharmacists can support providers to improve patient care

Nearly half the United States (U.S.) population takes prescriptions drugs, which means that pharmacists are an integral part of health care delivery. With nearly 3,000 community pharmacies in New York City, the community pharmacist may be the last checkpoint before a patient takes their medication and therefore, is uniquely positioned to support patient-centered care that complements services provided in the clinical environment.

Health care providers can rely on community pharmacists to help patients adhere to medication regimens. Medication adherence, or taking medications as prescribed, can impact patient outcomes and health care costs. Adherence rates of 80 percent or higher are typically needed for optimal therapeutic efficacy, however, adherence to chronic medications is estimated to be about 50 percent.[1,2] In the U.S., up to 50 percent of treatment failures, about 125,000 deaths, and at least 10 percent of hospitalizations each year can be attributed to nonadherence.[3,4]

Pharmacists assess medication adherence and can offer advice and support to overcome barriers to adherence. Pharmacists may suggest services such as free delivery, text reminders, automatic refills, and medication synchronization that allows patients to pick up their medications on the same day each month.

Pharmacists are also able to provide medication therapy management (MTM), a service aimed at helping patients enhance medication adherence and optimize medication therapy.

"The collaborative model of clinical pharmacists working with health care providers has proven to be associated with significant improvements in patients' medication-related health outcomes and a reduction in hospitalizations. The providers and pharmacists at our facility work as a team to develop, implement, and monitor patient-centered treatment plans, which are evidence based and cost effective."

- Dr. Ronnie Moore
Allure Specialty Pharmacy, Bronx

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Community Pharmacists and Health Care

How neighborhood pharmacists can support providers to improve patient care

Community pharmacists are dedicated to patient education. According to the U.S. Census, over 25 million people in the U.S. have limited English proficiency (LEP),[5] which means communicating effectively with LEP patients has become central to the provision of quality care in the U.S. Errors in communication are among the root causes of 59 percent of serious adverse events, and language barriers between health care providers and LEP patients can exacerbate these errors and lead to higher prevalence of adverse events among LEP patients.[6]

Pharmacists provide written and verbal counseling with each prescription, and may offer language services in the most commonly spoken languages in a particular neighborhood. Pharmacists also have the ability to print prescription labels in a patient's preferred language.

Pharmacists serve as a complement to clinical care for chronic conditions such as hypertension. Hypertension accounts for an estimated 25 to 50 percent of cardiovascular disease deaths in the United States.[7] In 2015, 29 percent of New Yorkers – about 1,847,000 adults - reported having hypertension.[8] Out-of-office blood pressure monitoring can help patients with hypertension manage their condition. Patients can visit their neighborhood pharmacy between routine clinical care visits to check their blood pressure. Many pharmacies offer free blood pressure monitoring.

The NYC HealthMap, a free online tool, can be used to locate pharmacies that offer free blood pressure checks with either a self-service kiosk or assistance from a pharmacist.

If you would like to learn more about how your patients can benefit from pharmacy services, contact pcippharmacy@health.nyc.gov. NYC REACH provides technical assistance to independent pharmacies throughout the city and can show your practice how to take advantage of their services.

What is the Hub?

Frequently Asked Questions

As New York City's public health agency, the Health Department aims to understand and promote the health of all New Yorkers. The Primary Care Information Project (PCIP), a bureau of the Health Department, uses data to support primary care practices in providing the best possible care for patients. The Hub Population Health System ("the Hub") is an automated tool that gives PCIP the practice-level insights it needs to serve NYC REACH member practices and track health statistics in New York City. PCIP developed this system with eClinicalWorks (eCW) to gather de-identified and aggregated information about groups of patients from eCW systems. The Hub does not collect patient identifiable information from electronic health record (EHR) systems. Below we share answers to NYC REACH member practices' questions about this unique tool for improving New Yorkers' health.

Is the Hub HIPAA-Compliant and Secure?

Yes. The Hub transmits patient counts to PCIP using an encrypted channel, and information is secured behind safeguards including encryption and firewalls. PCIP operates within all Health Department data security, privacy, and confidentiality policies. The Hub does not obtain any patient-identifiable information. It only receives and transmits answers to PCIP's questions in the form of patient counts. All patient-identifiable data remain with the practice. For example, PCIP might use the Hub to find out how many patients with a diagnosis of hypertension had an office visit this year, but PCIP does not use the Hub to retrieve those patients' names, dates of service, or other personal identifiers.

How Does the Hub Work?

PCIP sends a question (or "query") to the Hub. The Hub sends that question to practices connected to the Hub. The practices' EHR systems automatically return the answers to the Hub, and the Hub transmits the answers to PCIP through a secure channel. All Hub queries are in the form: "How many patients meet these criteria?" and all responses are in the form of a patient count. PCIP analyzes and shares this information with providers in easy-to-read, actionable reports. Neither eCW nor the Hub store any information after the Hub transmits the answers to PCIP. The Hub is only a mechanism for gathering and transmitting information to PCIP.

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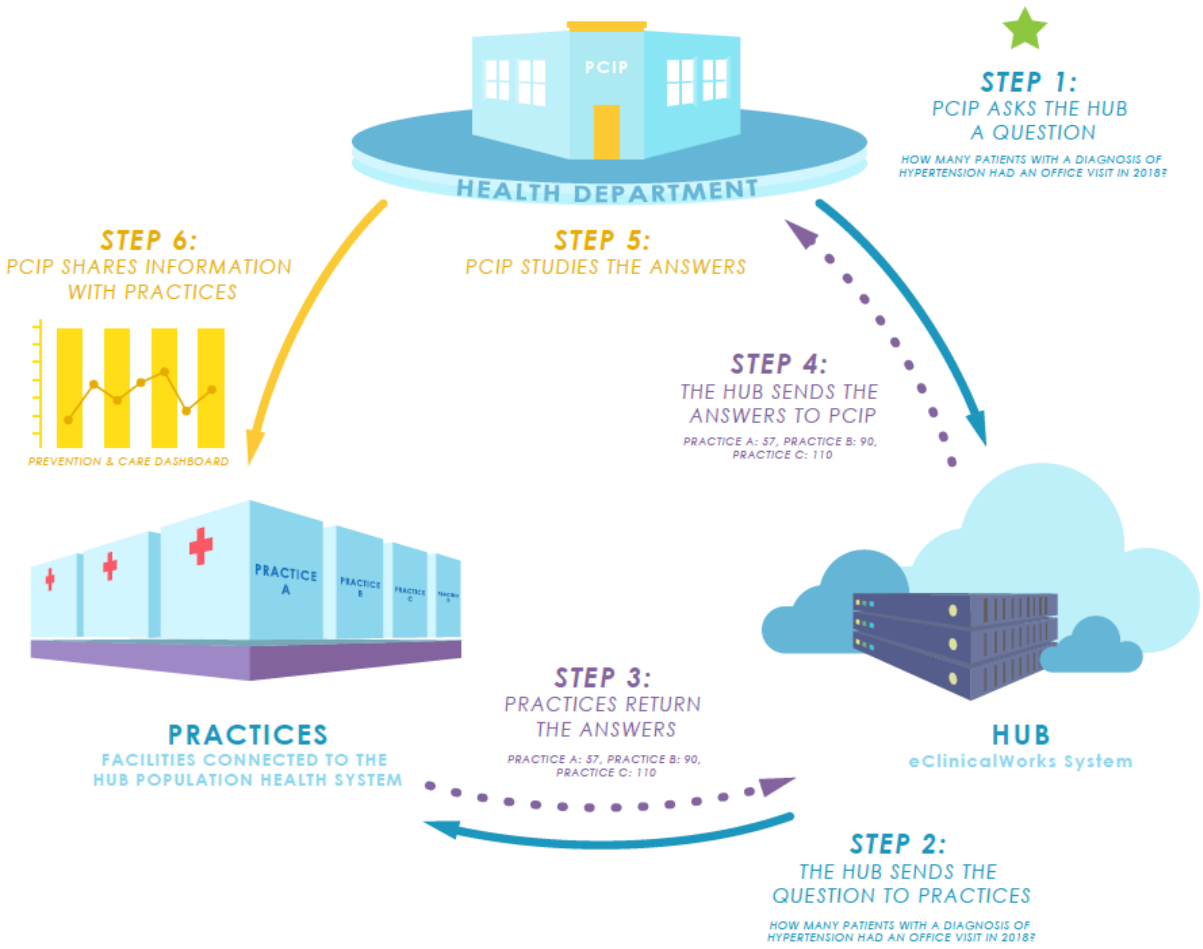
Follow these steps to learn the process for transmitting patient counts through the Hub.



How Does the Hub Help NYC REACH Practices?

Monthly reports

PCIP gathers patient counts to create "dashboard reports" for practices, which highlight opportunities for clinical intervention and identify patient populations that could benefit from community programs. These reports contain comprehensive information on a practice's patient population including smoking rates, blood pressure rates, A1C control rates, and more. These reports allow providers to identify areas for practice-level improvement and compare their performance to community averages.

Provider support and technical assistance

PCIP reviews this information with providers to address gaps in care and meet requirements for state and federal incentive programs, such as the Quality Payment Program and Meaningful Use. PCIP relies on this information to provide customized technical support for practices and recommend workflow changes to meet quality improvement goals.

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Which Practices Connect to the Hub?

The Hub can only connect to practices that use eCW and have an active NYC REACH Membership Agreement, through which practices authorize PCIP to gather patient counts through the Hub.

Practices can request to be disconnected from the Hub at any time. Practices that terminate their NYC REACH membership are automatically disconnected from the Hub. More than 700 NYC REACH member practices are connected to the Hub and nearly all of those are small primary care practices. These practices represent more than 6,000 providers and 2 million patients.

Who Can See Patient Counts?

PCIP staff are the first to receive and review patient counts. PCIP shares patient counts with providers in quality improvement dashboard reports. PCIP does not share patient counts that can be linked to a specific practice with anyone, unless the practice gives explicit consent. PCIP only shares patient counts with external groups if the practice gives explicit consent, and PCIP never shares patient counts for commercial purposes.

Does the Hub Affect How I Use My EHR?

The Hub does not interfere with any activity on an EHR. It operates completely in the background and requires no input from administrators or providers.

Are the Data Accurate?

Yes. PCIP conducts rigorous quality assurance and testing to validate all questions and answers transmitted through the Hub before use.

How Does the Hub Impact Public Health?

PCIP uses the Hub as a public health surveillance tool. PCIP studies patient counts to identify trends in conditions such as hypertension, influenza-like illness, depression, and Hepatitis C. These analyses help to determine how the Health Department employs resources to improve public health in New York City.

From Meaningful Use

to

Value-Based Payment

Value-based care (VBC) is a "value over volume," holistic approach to patient care. Value-based payment (VBP) arrangements reward providers for improving care quality, reducing costs and inefficiencies, and advancing population health. All payers, including the Centers for Medicare & Medicaid Services, are shifting away from traditional fee-for-service (FFS) models toward VBP models. New York State Medicaid plans to cover 80 percent of primary care services under VBP arrangements by 2020, and most commercial payers already offer VBP arrangements. This means providers need to modify their workflows now to meet VBP requirements.

Providers are making this transition already through state and federal programs, including the NY Medicaid EHR Incentive Program. The Program is a foundational step towards delivering value-based care, and was designed in stages to guide providers through the transition from FFS to VBP. Providers who attest to Meaningful Use Stage 3 will find themselves better positioned for success under VBP arrangements.

Stage 3 objectives help providers to strengthen their population health management skills, which are critical to success in the VBP landscape. Stage 3 objectives are designed to improve a provider's ability to:

- Identify opportunities for improvement in clinical quality, efficiency, and patient experience
- Track and monitor performance (eCQMs) across important services and conditions
- Track overutilization and other drivers of cost

The Program is active through 2021. Eligible Providers have three payment years left to attest to Meaningful Use Stage 3, which means they can still earn up to $25,500 in incentive payments.

NYC REACH encourages providers to participate in the program for as long as possible. This ensures they receive the maximum incentive payments available and helps to smooth the transition from FFS to VBP.

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The extra time providers put in now to attest to Meaningful Use will save them time in the future when they need to meet VBP requirements. The following chart shows how Stage 3 objectives reflect the goals of VBP arrangements.

Stage 3 Objective	Value-Based Payment Goals
How Stage 3 helps providers improve quality and empower patients	
Objective 3: Clinical Decision Support	Reduce care gaps, improve treatment protocols, and coordinate care effectively, which leads to improved patient outcomes
Objective 5: Patient Electronic Access to Health Information	Engage patients by providing information that helps them to manage and make decisions about their health
Objective 6: Coordination of Care through Patient Engagement	Encourage patients to be proactive about their care by allowing them to easily request appointments and clinical advice
How Stage 3 helps providers improve population health	
Objective 8: Public Health and Clinical Data Registry Reporting	Monitor quality and service gaps at the population level; help to create data transparency for providers to inform quality improvement efforts
How Stage 3 helps providers improve care coordination and reduce costs and inefficiencies	
Objective 1: Protect Patient Health Information	Increase health information exchange between providers, patients, and care settings with constant vigilance to protect PHI
Objective 2: Electronic Prescribing	Help providers avoid unnecessary costs by choosing the most cost effective medication; improve care coordination
Objective 4: Computerized Provider Order Entry (CPOE)	Improve efficiency by tracking outgoing orders, shortening turnaround times, improving readability; ensure patient safety by integrating CPOE with CDS
Objective 7: Health Information Exchange	Improve provider-provider communication by exchanging patient records, which reduces duplication of services, helps providers make informed treatment decisions, and increases patient satisfaction

Contact your NYC REACH specialist or pcip@health.nyc.gov to learn more.

Q&A

Q&A with Dr. Ravichandra, National Diabetes Prevention Program Lifestyle Coach

Dr. Papanna Ravichandra is a primary care physician with offices in Midtown and East Harlem. Since joining NYC REACH, he has participated in a number of quality improvement programs. He believes primary care providers can play an important role in guiding patients with prediabetes through lifestyle changes to prevent type 2 diabetes. To that end, he became a certified National Diabetes Prevention Program (National DPP) lifestyle coach in 2016. We asked him what it's like to host National DPP workshops, how he empowers patients, and how technology can improve population health.

Why did you become a lifestyle coach?

[Primary care providers] need to go and mingle with people, and this platform is like a kitchen table. It's less frightening; people are more welcome to share their feelings. It's not like an office, it's not like a molecular biology class. Patients just have to share what they do, talk about their lifestyle, then make some corrections. We need to create a model of healthy living. We need a system to turn "patient" back into "person." Structured programs like the National DPP do that.

There are many reasons people become lifestyle coaches. Some have worked in healthcare venues that treat patients with chronic disease, while others have personal experience seeing a friend or family member work through the burden of type 2 diabetes.

Whatever the reason, lifestyle coaches have passion for helping people live healthier lives. They possess strong interpersonal and group facilitation skills in order to create an environment where participants thrive and grow.

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Dr. Ravichandra hosts National DPP Workshops in a room with a big screen to show videos about nutrition and exercise.

Workshops take place every Wednesday. The consistent timing is easy for patients to remember and encourages compliance.

What's the key to delivering a successful National DPP?

I believe the key to scaling the program is to make it local, meaning classes have to be held within a 10-minute drive of patients' homes and led by a coach with local knowledge of neighborhood resources who can foster community-based, peer-to-peer connections.

Compliance is the key. We have reserved Wednesday for wellness every week. It's easy to remember. Patients consistently show up. They know the importance. They participate even better if you empower them with a microphone. They love to say something.

The technology exists. The reimbursement exists. You can structure the timing, the reimbursement, or what have you, and you can make it work.

How important is preventive care?

The only cure is prevention. It's the single best way. If you don't manage medical conditions, the conditions manage you. From a cost perspective, preventive health care is significantly cheaper than treating disease. Payers are actively encouraging their policy holders to take preventive measures and are gladly footing the bill. Addressing social determinants of health as a preventive health care strategy has begun to emerge in recent years.

How does technology help?

Approximately 95 percent of Americans have a mobile phone of some kind,[9] and like any sector, health care has had to transform its processes to connect with people easily and efficiently. Mobile health apps offer greater flexibility to all parties. They're one of the most inexpensive ways for facilities to provide stronger services to their patients. Through the use of apps and attachments, smartphones also can better inform patients who need to continually monitor their conditions.

For example, in one study, patients with diabetes and uncontrolled hypertension who used a smartphone app were able to significantly reduce their blood pressure within six weeks.[10] Some work to create

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better health awareness while others facilitate communication between patient and care provider.

Sometimes patients come to this table and get their family members on the TV. I help them connect to Google Chrome. I have a family member calling from Seattle calling her grandpa here in NYC. I can say look, your grandfather is sad because you're far away, he's back to eating poorly, he hasn't slept, he's not taking his medicines. So the granddaughter comes on the TV and talks to him about it.

A room for group discussion

How do you empower patients?

Changing the waiting room game helps increase the level of participation. I think every office should be a living room, so there's no waiting room. Patients have internet access, they have USB chargers, TVs. I want them to feel better when they leave, or at least begin to feel better.
Every place should be a healing place. It reduces patient anxiety. Participation is then excellent.

The National DPP is an evidence-based, lifestyle change prevention program that follows a CDC-approved curriculum. Primary care providers can deliver the National DPP by becoming certified lifestyle coaches. National DPP providers can now bill Medicare for services under the expanded Medicare DPP.

Contact **pcip@health.nyc.gov** to learn more about the benefits of the program and how to get involved.

References

1. Kim J, Combs K, Downs J, Tillman F III. Medication Adherence: The Elephant in the Room. *US Pharm.* 2018;43(1)30-34.

2. Viswanathan M, Golin CE, Jones CD, et al. Interventions to Improve Adherence to Self-administered Medications for Chronic Diseases in the United States: A Systematic Review. *Ann Intern Med.* 2012;157:785–795.

3. U.S. Food and Drug Administration. Why You Need to Take Your Medications as Prescribed or Instructed. https://www.fda.gov/drugs/special-features/why-you-need-take-your-medications-prescribed-or-instructed. Accessed November 7, 2019.

4. Viswanathan M, Golin CE, Jones CD, et al. Interventions to Improve Adherence to Self-administered Medications for Chronic Diseases in the United States: A Systematic Review. *Ann Intern Med.* 2012;157:785–795.

5. Zong, J and Batalova, J. (2015, July 8). *The Limited English Proficient Population in the United States.* Migration Policy Institute. Retrieved from: https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states.

6. Wasserman M, Renfrew MR, Green AR, Lopez L, Tan-McGrory A, Brach C, Betancourt JR. Identifying and Preventing Medical Errors in Patients With Limited English Proficiency: Key Findings and Tools for the Field. *J Healthc Qual.* 2014;36(3): 5-16.

7. Patel SA, Winkel M, Ali MK, Narayan KM, Mehta NK. Cardiovascular mortality associated with 5 leading risk factors: National and state preventable fractions estimated from survey data. *Ann Intern Med.* 2015;163: 245-253.

8. New York City Department of Health & Mental Hygiene. Hypertension in New York City: Disparities in Prevalence. *Epi Data Brief.* 2016;82. https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief82.pdf. Accessed November 1, 2019.

9. Mobile Fact Sheet. Pew Research Center. https://www.pewinternet.org/fact-sheet/mobile/. Accessed June 12, 2019.

10. Shah BR, Xu T, Bollyky JB, Lu W, Painter S. Remote Monitoring of Blood Pressue in T2D Population Decreases Systolic Blood Pressure at 6 Weeks: A Pilot Study. *J Am Coll Cardiol.* 2019;73 (9 Supplement 2):18.

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.

CONTACT US

Primary Care Information Project
2 Gotham Center
42-09 28th Street
Long Island City, New York, 11101

Email: pcip@health.nyc.gov | **Call**: 347.396.4888

Visit: www.nycreach.org

Questions about this newsletter? Contact pcipcomms@health.nyc.gov.

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