EvidenceNOW
Advancing Heart Health in Primary Care

HealthyHearts NYC
Primary care partnerships advancing heart health

New York City Cooperative

EvidenceNOW: Advancing Heart Health in Primary Care is an initiative of the Agency for Healthcare Research and Quality (AHRQ) to transform health care delivery by building a critical infrastructure to help smaller primary care practices improve the heart health of their patients by applying the latest medical research and tools. EvidenceNOW established seven regional cooperatives composed of public and private health partnerships that provide a variety of quality improvement services typically not available to small primary care practices. The goal of this initiative is to ensure that primary care practices have the evidence they need to help their patients adopt the **ABCS** of cardiovascular disease prevention: **A**spirin in high-risk individuals, **B**lood pressure control, **C**holesterol management, and **S**moking cessation. The initiative also includes an independent national evaluation designed to determine if and how quality improvement support can accelerate the dissemination and implementation of new evidence in primary care.

Cooperative Name:
HealthyHearts NYC
chcanys.org/healthyhearts

Principal Investigator:
Donna Shelley, M.D., M.P.H., New York University School of Medicine

Cooperative Partners:
New York University School of Medicine
New York City Department of Health and Mental Hygiene Primary Care Information Project (PCIP)
Community Health Care Association of New York State (CHCANYS)

Geographic Area:
New York City

Project Period:
2015-2018

Region and Population

With 8.5 million people, New York City (NYC) is the most populous city in the United States. It also is one of the most diverse (29 percent Hispanic, 25.5 percent African American, and 13 percent Asian).[1] Heart disease is the primary cause of death in the city, and prevalence of cardiovascular disease (CVD) risk factors is high: a 2012 survey of 10,000 adults found that 28 percent had hypertension, 29 percent had high blood cholesterol, and 15 percent used tobacco.[2] Residents of the poorest neighborhoods consistently have higher mortality rates from almost all diseases, including CVD, compared with residents of higher income neighborhoods.[3,4]

Specific Aims

1. Compare the effect of practice facilitation with usual methods of patient care on implementation of ABCS recommendations.
2. Explore potential organizational-level mechanisms that may contribute to and explain the impact of practice facilitation on ABCS outcomes.
3. Use qualitative methods to assess factors that help and hinder practices in implementing change and achieving ABCS outcomes.
4. Disseminate findings to key primary care professional organizations, policy makers, payers, purchasers, consumer groups, and other stakeholders to ensure that national, State, public, and private institutions support, incentivize, continue to study, and apply effective practices.

AHRQ Agency for Healthcare Research and Quality
NATIONAL CENTER FOR EXCELLENCE IN PRIMARY CARE RESEARCH

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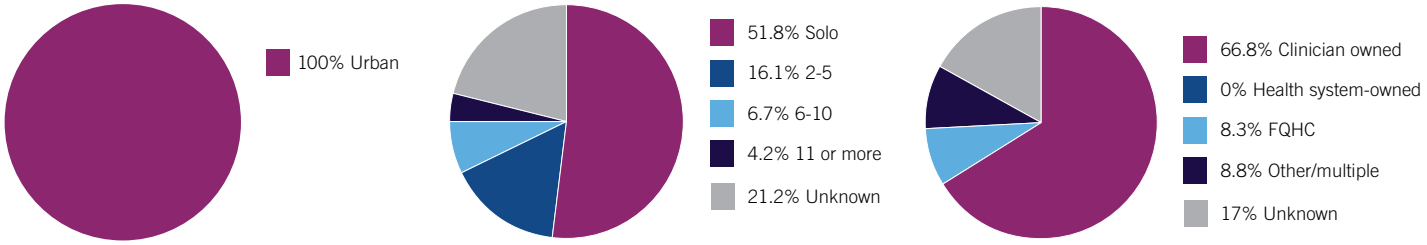
Reach: Number of Participating Practices: **276**



Location | Number of Clinicians | Ownership

Note: These preliminary data are provided for illustrative purposes. Numbers are subject to change based on final data analyses. Data courtesy of ESCALATES, the EvidenceNOW independent national evaluator under AHRQ grant number R01HS023940-01. For more information about the national evaluation, visit: www.escalates.org

UPDATES ON KEY PROJECT COMPONENTS

Support Strategy

Practice facilitation focuses on helping sites implement evidence-based components of the Chronic Care Model. Practices are supported by one-on-one tailored facilitation combined with opportunities for shared learning across intervention sites. The facilitation consists of:

- *Monthly onsite practice facilitation meetings* to encourage system changes to support ABCS-driven care
- *Three expert webinars* on topics related to evidence-based management of CVD risk factors
- *Peer-to-peer learning activities* to allow practices to engage with each other, share best practices, and present data from their quality improvement activities
- *Telephone and email exchanges with practices* as needed

Updates

The New York City Cooperative is working with practices through two organizations. Most of the participating practices (257) are part of the Primary Care Information Project, or PCIP, a bureau of the city's Department of Health and Mental Hygiene that provides technical assistance to small practices in underserved areas. Nineteen additional practices are members of the Community Health Care Association of New York State, or CHCANYS, which represents FQHCs in the State.

Some highlights include:

- The New York City Cooperative has had minimal attrition, with more than 85 percent of sites remaining in the study.
- The study has provided the opportunity to compare the impact of practice facilitation on small independent practices with its impact on Federally Qualified Health Centers.
- With access to a data hub (PCIP) and data warehouse (CHCANYS), practice facilitators are able to provide practices with summary panel reports and dashboards to support their ongoing quality improvement work and help sustain improvement after the intervention ends.
- Peer-to-peer learning sessions hosted by providers in their offices have provided opportunities for providers and their staff to learn from each other and build a network of contacts in their geographic area.

Evaluation

The cooperative is using a stepped-wedge design. The intervention is 12 months long and all sites were randomized into four intervention waves at the start of the study. Each wave starts 3 months after the start of the prior one, with all sites eventually receiving the intervention.

Updates

The New York Cooperative is gathering an extensive array of quantitative and qualitative data. The PCIP data hub and CHCANYS data warehouse make it possible to extract data on the ABCS measures directly from the study sites' EHRs. To track the intervention and resulting practice changes at PCIP sites the Cooperative is using the customer relationship management (CRM) platform, Salesforce. To collect the same data for CHCANYS sites, Cooperative staff use RedCap, a secure web application for building and managing online surveys and databases. The team has observed practice facilitators delivering the intervention on site at the practices and interviewed practice facilitators, key players from PCIP and CHCANYS, and providers and key staff at a selection of practices.

Comment from Principal Investigator

"Working in these very small practices, we are seeing how much they are part of their communities. The doctors live in the same neighborhoods as their patients. They speak the same language. They are important figures in their patients' lives and without these doctors, these patients might not even seek care. When you support a practice like this, you are supporting the wellbeing of a community."

Donna Shelley, M.D., M.P.H.

Publications and Other Dissemination Activities

Publication:

Testing the Use of Practice Facilitation in a Cluster Randomized Stepped Wedge Design Trial to Improve Adherence to Cardiovascular Disease Prevention Guidelines: HealthyHearts NYC [Implementation Science, 7/4/16]

Presentations:

- How practice characteristics drive differences in the external practice facilitation (PF) process: a comparative analysis of PF in Federally Qualified Health Centers and small independent primary care practices [AcademyHealth, 2017]
- Using Customer Relationship Management software to monitor and enhance external facilitation in small to medium size primary care practices [AcademyHealth, 2017]
- Using Practice Facilitation in primary care settings to reduce risk factors for cardiovascular disease: Burnout analysis [SGIM, 2017]
- Applying implementation frameworks to quality improvement in small practices [New York City Department of Health and Mental Hygiene, Epidemiology Grand Rounds Speaker, 2016]
- Practice Facilitation to Advance Practice Transformation in NYS Federally Qualified Health Centers [New York Academy of Medicine, Population Health Summit, 2016]
- Using Practice Facilitation in primary care settings to reduce risk factors for cardiovascular disease: Baseline analysis [New York Academy of Medicine, Population Health Summit, 2016]
- Panel on Health and Healthcare [NYU School of Medicine Department of Population First Annual "Health and..." Conference, 2016]
- Using Practice Facilitation in primary care settings to reduce risk factors for cardiovascular disease: Data harmonization [APHA, 2016]

[1] *https://www.census.gov/quickfacts/fact/table/newyorkcitynewyork/PST045216. Accessed August 17, 2017.*

[2] *The New York City Department of Health and Mental Hygiene. New York City Community Health Survey. https://www.health.ny.gov/statistics/leadingcauses_death/nyc_by_year.htm Access August 17, 2017.*

[3] *Health Disparities in Life Expectancy and Death. New York: New York City Department of Health and Mental Hygiene; Health Disparities in New York City, April 2010, No. 1.*

[4] *Myers C, Olson C, Kerker B, et al. Reducing Health Disparities in New York City: Health Disparities in Life Expectancy and Death. New York: New York City Department of Health and Mental Hygiene; 2010.*