



***HealthyHearts NYC***  
***Primary Care Partnerships Advancing Heart***  
***Health Initiative***

**CHCANYS Participation Guide**

**[Insert Health Center Name]**

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*HealthyHearts NYC is a cooperative of the Agency for Healthcare Research and Quality's EvidenceNOW initiative to advance heart health in primary care.*



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# ***HealthyHearts NYC Initiative:*** **Background and Aim**

## **Background:**

With 8.3 million people, New York City (NYC) is the most populous and diverse city in the United States (26% Hispanic, 26% African American, and 13% Asian).<sup>1</sup> 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.<sup>2</sup> Residents of the poorest neighborhoods consistently have higher mortality rates from almost all diseases, including CVD, compared with residents of higher income neighborhoods.<sup>3,4</sup>

The Community Health Care Association of New York State (CHCANYS) has partnered with the Department of Population Health at the New York University School of Medicine (NYUSOM) and the NYC Department of Health and Mental Hygiene's (NYCDOHMH) Primary Care Information Project (PCIP) to launch *HealthyHearts NYC*, a three-year project funded by the Agency for Healthcare Research and Quality (AHRQ). *HealthyHearts NYC* is one of seven (7) cooperatives in the country selected to work on activities to improve CVD health. This quality improvement research study will focus on using practice facilitation/on-site coaching to improve adherence to the ABCS evidence-based guidelines: Aspirin as appropriate (A), Blood pressure control (B), Cholesterol management (C) and Smoking cessation (S). As the grantee, NYUSOM will be responsible for all data collection (surveys and measures), as well as evaluation, analysis and dissemination. CHCANYS will be delivering the practice facilitation, and other corresponding intervention elements and activities.

The *HealthyHearts NYC* project partners are committed to developing infrastructure intended to support a systematic approach to optimize CVD prevention and management in high risk patients. Moreover, a more efficient and streamlined system of delivery of care will be achieved among participating sites, through the introduction and use of tools and resources. Proper documentation within the EHR, data validation and analytics will serve as the foundation for genuine practice transformation. Practice site designated QI teams will participate in a 12 month practice facilitator led intervention which focuses on using data from the Center for Primary Care Informatics (CPCI) to drive improvements, as well as redesigning workflow processes to create efficiencies in CVD disease management and prevention.

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<sup>1</sup> <http://www.furmancenter.org>. Accessed April 25, 2015.

<sup>2</sup> The New York City Department of Health and Mental Hygiene. New York City Community Health Survey. <http://www.nyc.gov/html/doh/html/data/survey.shtml>. Accessed April, 25, 2015.

<sup>3</sup> Karpati A, Kerker B, Mostashari F, et al. Health Disparities in New York City. New York (NY): New York City Department of Health and Mental Hygiene; 2004.

<sup>4</sup> Myers C, Olson C, Kerker B, et al. Reducing Health Disparities in New York City: Health Disparities in Life Expectancy and Death. New York (NY): New York City Department of Health and Mental Hygiene; 2010.

**Overall Project Aim:**

The overarching goal of this project is to ensure FQHCs have the latest evidence on cardiovascular health, that they use it to reduce CVD risk to help their patients live healthier and longer lives. Aligning with the Million Hearts ABCS, a coordinated national effort to prevent one million heart attacks and strokes by 2017, *HealthyHearts NYC* will assist participating FQHCs by providing the resources and skills needed to make relevant and sustainable workflow and systems changes in order to improve the CVD risk reduction rates in their communities. Through *HealthyHearts NYC*, NYUSOM will test whether external practice facilitation (QI support) accelerates the implementation and adoption of evidence based policies and procedures for preventing and treatment of CVD.

The intervention has been developed and guided by key practice transformation elements including but not limited to:

- The Chronic Care Model ([Appendix C](#));
- The Model for Improvement ([Appendix D](#))
- Population health management ([Appendix H](#))
- Team-based care ([Appendix I](#))
- Engaged, empowered patients ([Appendix J](#))

During your 12 month active intervention period, your practice site team will participate in activities aligned with Chronic Care Model (CCM) framework. These activities will be carried out primarily during onsite monthly QI practice facilitation meetings in addition to three (3) expert webinars and peer-to-peer collaborative activities. (See [Appendix A: HealthyHearts NYC Activities Calendar](#))

Your health center's Practice Facilitator for *HealthyHearts NYC* will be [Insert PF name]. [PF name] will maintain regular contact with your team through in-person site visits, e-mail and conference calls. Team members may contact her using the following information:

[Insert PF contact information]

# Structure of the Project: Key Drivers to Improve ABCS Compliance

See [Appendix A](#) for *HealthyHearts NYC* Activities Calendar for more information.

## Data Feedback & Monitoring

The core metrics chosen for the *HealthyHearts NYC* align with a variety of state and federal initiative measurements such as, but not limited to: Meaningful Use, National Quality Forum (NQF), Uniform Data System, Delivery System Reform Incentive Payment (DSRIP) Program, and Patient Centered Medical Home (PCMH), making them the best choice for this project. A full description of the metrics can be found in [Appendix B](#).

The data monitoring aspect of this project will be based on data housed in the CHCANYS Center for Primary Care Informatics (CPCI). CPCI is a member FQHC data warehouse that extracts information from FQHC electronic health record (EHR) products, calculates measures using uniform specifications, and features a performance dashboard where providers can compare their performance to other practices and benchmarks. Metrics for CVD have been built into the CPCI database. The 5 CPCI tools that will be used extensively throughout the course of this project include:

- 1) ABCS report
- 2) ABCS measure analyzers
- 3) ABCS registry
- 4) Patient Visit Planning report
- 5) Referral Management report (relevant to those sites that have purchased this tool)

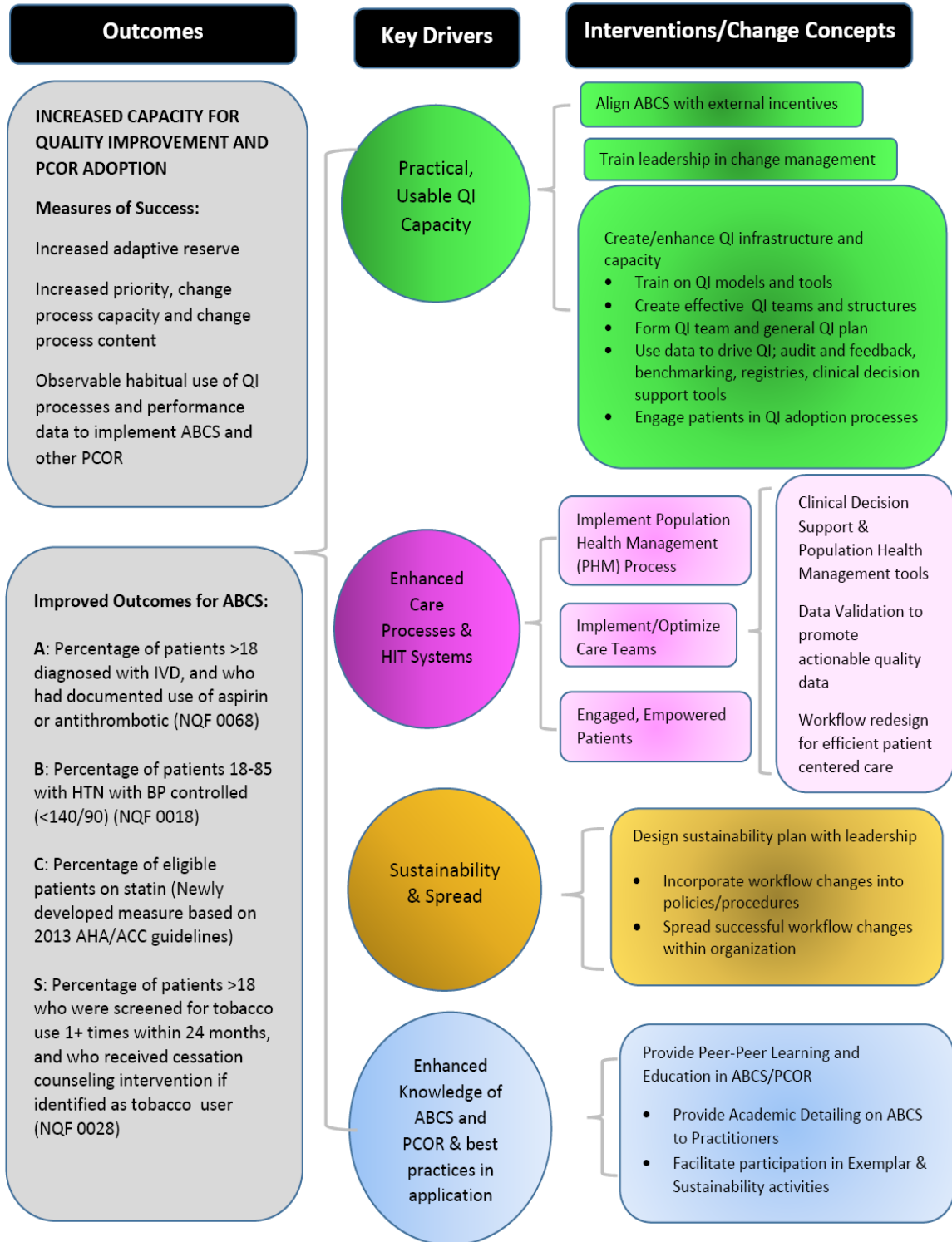
## Practice Facilitation

What is Practice Facilitation? In general terms, Practice Facilitation (PF) is provided to primary care practices by a trained individual or team of individuals. These individuals use a range of organizational development, project management, QI, and practice improvement approaches and methods to build the internal capacity of a primary care practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals. This support may be provided on site, virtually (through phone conferences and Webinars), or through a combination of onsite and virtual visits.<sup>5</sup> In the research literature, PF is sometimes called quality improvement coaching or practice enhancement assistance. Many experts believe that external facilitators are more effective because they support multiple practices and don't face the same competing demands as internal facilitators, who sometimes are reassigned to meet other daily or acute needs. Facilitators provide interventions that vary in intensity, scope, and duration but, broadly speaking, PF recognizes change as an ongoing process.<sup>5</sup>

In order to drive change at the site level, the *HealthyHearts NYC* Initiative will focus on delivering the intervention through practice facilitation (PF). For the purposes of this project, the PF will assist the health centers' QI and care teams, and physicians in providing external expertise on practice redesign based on the principles of the CCM. Additionally, the PFs will promote and implement a tailored approach in aligning your practice site with the ABCS guideline-concordant care to improve patient outcomes. In addition, the tools and resources used throughout the duration of the intervention are intended to help the site build capacity to incorporate evidence-based guidelines into practice, as well as provide more efficient and timely patient care through QI capacity development, implementation of population health management, optimized care teams and engaged, empowered patients with a focus on sustainability of effective practice changes beyond the 12 month project period.

Please find below the key driver model diagram, which outlines the key activities that will take place at your participating site(s) that will result in the subsequent outcomes of increased QI capacity and adherence to the ABCS metrics, which will invariably lead to improved outcomes for your patient populations.

## CHCANYS ABCS Key Driver Model



# Forming QI Teams

## Selecting QI Team Members at Your Health Center

Selecting appropriate staff to serve as QI team members at your health center is a key component of successful QI efforts, and a necessary part of this initiative. Senior leadership is ultimately responsible for choosing appropriate team members to build an effective team that will carry through your health center's QI projects. Here are some characteristics to consider:

- First and foremost, team members should be committed to making the changes that will contribute to their patients' and families' ability to obtain the highest quality care possible. This may include staff members who are already passionate about chronic disease management or who currently champion/advocate for adopting systems changes. Conversely, staff members who express frustration over current health center processes may also serve as ideal team members. Having the opportunity to serve on a QI team may empower participating staff to make changes that will result in addressing real and current needs and system gaps.
- Teams should be multidisciplinary and include members that represent the perspectives of both direct or clinical (e.g., medical provider, nurse) and non-direct or administrative (e.g., front desk, health information technology) patient care staff. Diverse team members will provide the team with varied skill sets that can be used in QI efforts to ensure comprehensive care. Generally, consider staff members who are committed; supportive; competent; proactive with their current responsibilities; and interested in making changes to improve the care of your health center's population. Lastly, team members should have enough time to dedicate themselves to a 12-month commitment that will require time and effort to participate in team activities.

## Individual Team Member Responsibilities

Team activities will be guided by a Team Leader, Provider Champion, QI/EHR Leader and selected support members. Individuals in these roles will represent the team during peer to peer learning sessions, face-to-face learning sessions and webinars with the responsibility of sharing their learning with other team members. Descriptions for each team member role are listed below.

A team's appointed ***Provider Champion...***

- Serves as a practicing provider who is an opinion leader and is well respected by peers;
- Understands the processes of care in the health center;
- Has a good working relationship with colleagues; and
- Wants to drive improvements in the health center network or satellite sites.

The Provider Champion will be a critical member of the QI team. This person creates buy-in to participate in QI projects like those described in this packet and oversees recruitment of QI team



members. The Provider Champion is expected to attend most of the monthly QI collaboration calls and webinars and all face-to-face learning sessions (as described above).

A team's appointed **Team Leader...**

- Reports team's success and progress to the team;
- Drives QI projects and ensures that QI activities and Plan Do Study Act (PDSA) cycles are tested and implemented;
- Coordinates communication between the team and CHCANYS;
- Works effectively with the Provider Champion; and
- Oversees running of CPCI reports and identifies trends in data.

The Team Leader should understand how changes will drive system changes at your health center. The Team Leader is expected to attend all QI technical assistance activities (as described above) or send another team member in their place if necessary.

A team's appointed **Quality Improvement/EHR Leader...**

- Monitors and maintains the quality measure reports within CPCI and assists the team with the analysis of those reports in order to drive QI activities
- Troubleshoots data collection by working with appropriate health information technology/information systems staff at the health center, CHCANYS and Azara Healthcare

The QI/EHR Leader should have a working knowledge of the health center's electronic medical record system and the CPCI. The QI/EHR Leader is expected to participate in all QI technical assistance activities (as described above).

**Other team members...**

In addition to team core members, the team can include members with different skill sets to create a multidisciplinary team. Examples of other members could include Registered Nurses, Health Educators, Patient Navigators/Advocates, Medical Assistants and Front Desk staff.

# QI Team Goals

**Instructions for Appendices E and G:** During our first two on-site meetings we will together be working through the tools attached in Appendix E and Appendix G, to identify your team's goals, and outline Aims. To note, Appendices E and G do not need to be completed prior to our first on site meeting,

Each participating practice site team will be required to develop SMART goals for improving their CVD rates. Identification of these goals will drive team decisions around which system improvements to implement and test using the Care Model and Model for Improvement. Team goals will be shared with each site's practice facilitator at CHCANYS during coaching meetings and on follow-up calls. When thinking about SMART goals, always begin by referencing the Model for Improvement and identify, *what are we trying to accomplish?*

## Creating SMART Goals

While creating your team's goals, please consider the SMART methodology.

<b>Specific:</b>	Goals should be understandable and unambiguous.
<b>Measurable:</b>	It is best to have numeric goals.
<b>Actionable:</b>	The following questions should be answered: --Who? --What? --Where? --When?
<b>Achievable:</b>	As a team, each team member should feel that their goal is a challenge for the health center but is achievable.
<b>Relevant:</b>	The goal should be related to the mission and vision of your health center and its stakeholders.
<b>Timely:</b>	Goals should include a specific timeframe to encourage an end point.

# QI Participation Guide Appendices

## Appendix A: *HealthyHearts NYC Activity Calendar*

Project Timeline of Activities	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Aug 2017
Beginning of NYU Baseline survey data collection	X	X													
Onsite PF Launch#1		X													
Onsite PF Launch#2		X													
PF Onsite Coaching Visits			X	X	X	X	X	X	X	X	X	X	X		
Expert Webinar			X	X	X										
NYU end of intervention survey data collection														X	
NYU 6 months post-intervention survey data collection															X

# Appendix B:

## HealthyHearts NYC: CVD Outcome Measures

	<b>What is measured</b>	<b>Why it is measured</b>
<b>Aspirin as appropriate</b>	Percent of patients 18 and older diagnosed with IVD who are on aspirin or another antithrombotic	To determine if patients with IVD are on aspirin or another antithrombotic. Long-term aspirin therapy confers conclusive net benefits on risk of subsequent MI, stroke and vascular death among patients with a wide range of prior manifestations of CVD.
<b>Blood pressure control</b>	Percent of patients 18-85 diagnosed with HTN who had last BP controlled (< 140/90)	To determine the number of patients with controlled hypertension. Hypertension increases the risk for heart disease and stroke.
<b>Cholesterol management</b>	Percent of patients 21 and older diagnosed with ASCVD who are on statin therapy + Percent of patients 21 and older with history of LDL $\geq$ 190mg/dL who are on statin therapy + Percent of patients 40-75 with diabetes who are on statin therapy	To determine if statin therapy for prevention and treatment of CVD is being prescribed for those in the 1st, 2nd, and 3rd statin benefit groups. This composite score shows total statin use in those that may most benefit.
<b>Smoking Cessation</b>	Percent of patients 18 and older who had smoking status updated in the last two years	To determine the number of patients who were screened for smoking status. Although this measure shows a 2 year look back for documentation of smoking status, the best practice guideline is to make sure that for every patient at every clinic visit, tobacco-use status is queried and documented.
	Percent of patients 18 and older identified as current smokers who received cessation intervention or counseling	To determine the number of patients who were counseled on tobacco use. Counseling includes smoking cessation intervention in the form cessation counseling &/or pharmacologic therapy.

*\*Please note that these measures will be collected by AHRQ EvidenceNOW.*

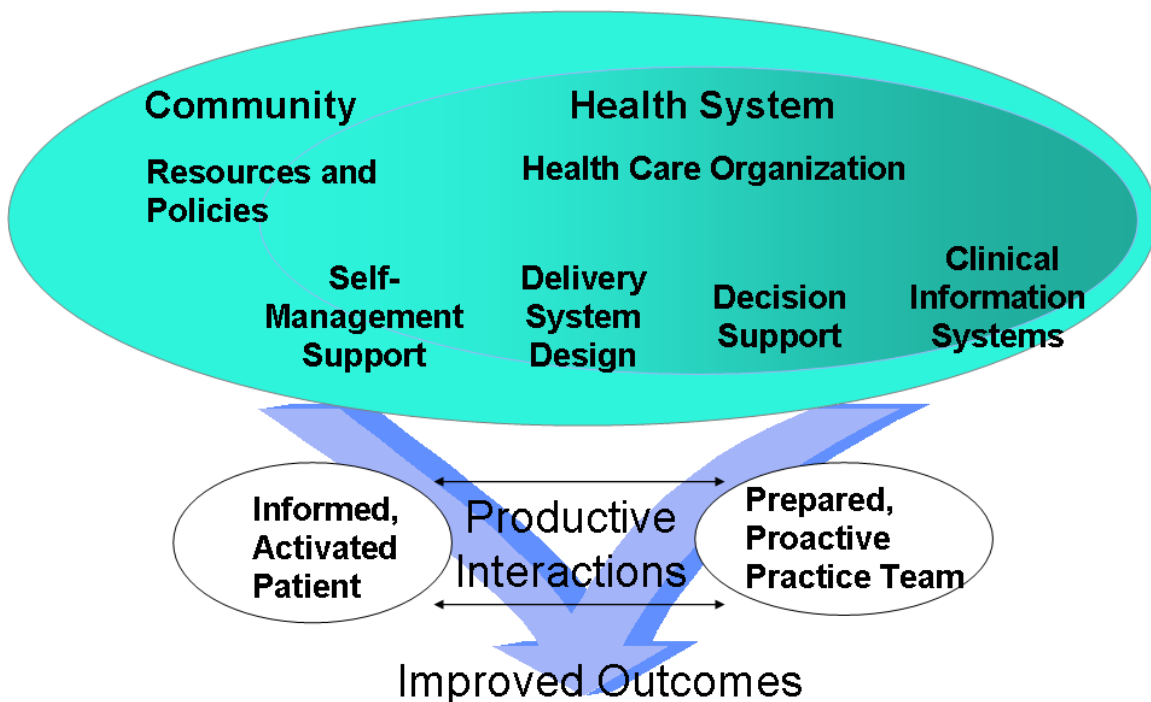
A more comprehensive list of measures and their definitions will be shared by your PF.

## Appendix C: Overview of the Chronic Care Model

### The Chronic Care Model

The Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The Model can be applied to a variety of chronic illnesses, health care settings and target populations. The bottom line is healthier patients, more satisfied providers, and cost savings.

More detail is available on the Institute for Healthcare Improvement's web site:  
[http://www.improvingchroniccare.org/index.php?p=The\\_Chronic\\_Care\\_Model&s=2](http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2)

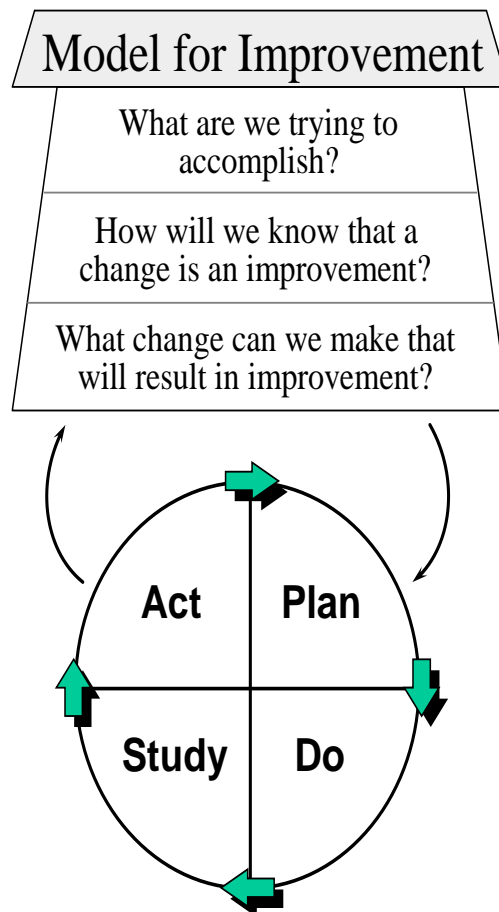


# Appendix D: Overview of the Model for Improvement

## The Model for Improvement

The Model for Improvement is a simple yet powerful tool for accelerating QI changes in your health center. The model has two parts. In the first part, your team will address three fundamental questions. These questions will guide your team in creating aims, measures, and specific change ideas. Secondly, your team will use Plan-Do-Study-Act (PDSA) cycles to easily test these changes in your work environment. Successful tests of change pave the way for real-world implementation within your system. A brief synopsis of the model is presented below.

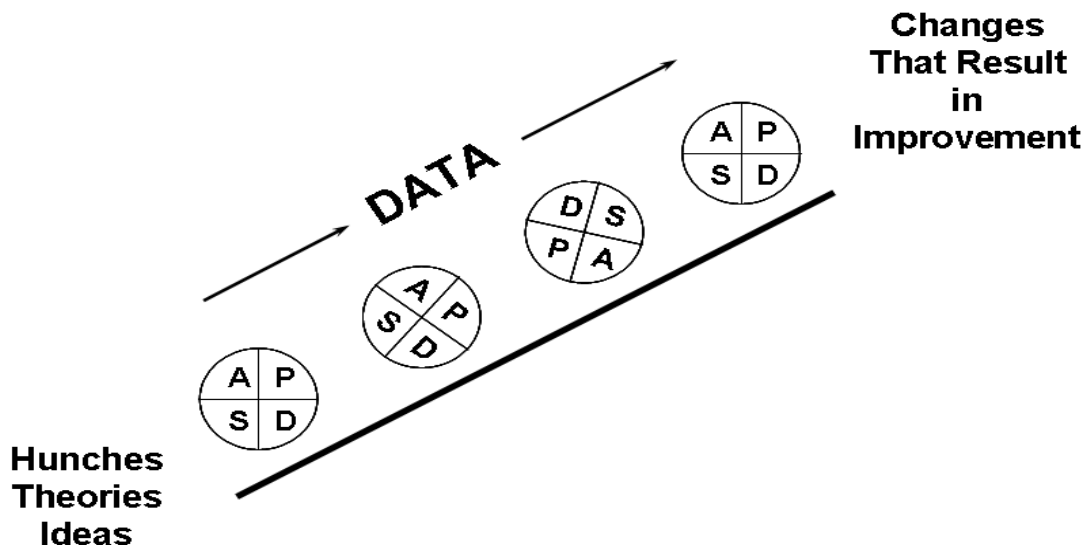
More details are available on the Institute for Healthcare Improvement's web site: <http://www.ihl.org>  
<http://www.ihl.org/IHI/PAics/Improvement/ImprovementMethods/HowToImprove/>



## Plan-Do-Study-Act (PDSA) Cycles

The PDSA cycle is a method for rapidly testing a change - by planning it, trying it, observing the results, and acting on what is learned. This is a scientific method used for action oriented learning. After changes are thoroughly tested, PDSA cycles can be used to implement or spread change. The key principle behind the PDSA cycle is to test on a small scale and test quickly. Traditionally, QI has been anchored in laborious planning that attempts to account for all contingencies at the time of implementation; usually resulting in failed or partial implementation after months or even years of preparation. The PDSA philosophy is to design a small test with a limited impact that can be conducted quickly (days if not hours!) to work out unanticipated “bugs”. Repeated rapid small tests and the learning’s gleaned build a process ready for implementation that is far more likely to succeed. **Parts of the PDSA cycle include:**

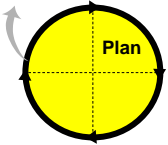
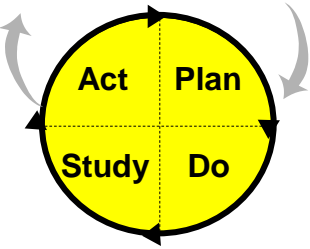
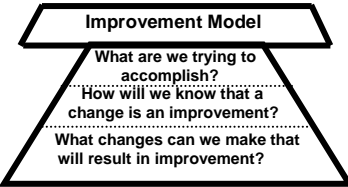
- **Plan** – In this phase, your objectives are defined and your team makes predictions about what will happen, and why it will happen. Your team will also prepare for the next step by answering the questions of who, what, where, and when.
- **Do** – In this phase, your team will carry out the plan and collect the data. This will include documenting experiences, problems, and surprises that occur during this test cycle.
- **Study** – In this phase, your team will analyze the test cycle and reflect on what you have learned. You will compare results with the predictions made in the planning stage, and draw conclusions based on the collected data.
- **Act** - In this last phase, your team will decide if there are any refinements or modifications needed to the change you have tried. This may lead to additional test cycles, which starts the process all over again with **Plan**



# Appendix E: PDSA Cycle Worksheet

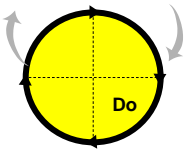
## PDSA Cycle Implementation

This worksheet will be completed in Q2-4 of the project implementation, once the required pre-planning work is performed. The QI team will need to focus our efforts on a targeted challenge, and formulate a **SMAART** goal (**S**pecific, **M**easurable, **A**ctionable, **A**ttainable, **R**ealistic, and **T**imely). Goals should be small and incremental:



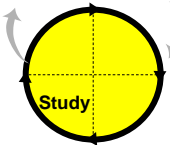
**Step 1: PLAN** – Once you have identified the weak process, assign roles and responsibilities

List of tasks	Team member Responsible	When	Where	What
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				



**Step 2: DO** - Create a pilot project to improve the process, and document your process – Remember to start small!

What are your experiences with the cycle?	
List problems you have encountered	
Describe surprises that have arisen	

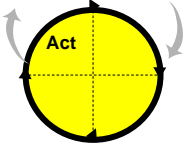


**Step 3: STUDY** – See if the action worked by **studying the data** (quantitative and qualitative). If no improvement was made, cycle back to “Do”

- Include baseline data, monitoring data, and your goal. Present at your structured team meeting.

	Numerator	Denominator	Rate	Explanations
Week 1 - <b>baseline</b>				
Week 2				
Week 3				
Week 4				





**Step 4: ACT – Document and summarize what was learned. If the pilot worked, focus on sustaining and spreading the success. Continue to monitor through data validation.**

- List conclusions from this cycle
  - 1)
  - 2)
  - 3)
  
- What are next steps?
  - How do we sustain current improvements?
  - Should we expand the size and scope of the cycle or implement as is?
  - Should we expand the pilot to other areas (i.e. providers, department-wide, sites, workflow areas or diseases?)
  - What changes are needed for the next cycle?
  - 1)
  - 2)
  - 3)

# Appendix F:

## Tips for Setting Aims

(from the Institute for Healthcare Improvement)

- 1. State the aim clearly.** Achieving agreement on the aim of a project is critical for maintaining progress. Teams make better progress when they are very specific about their aims. Make sure that the aim statement describes the system to be improved, and the patient population. In addition, ensure that the aim gives guidance on the approaches to improvement.
- 2. Include numerical goals that require fundamental change to the system.** Teams are more successful when they have unambiguous, focused aims. Setting numerical goals clarifies the aim, helps to create tension for change, directs measurement, and focuses initial changes. For example, the aim "Reduce operating room time" is not as effective as "Reduce operating room time by 50% within 12 months." Including numerical goals not only clarifies the aim but also helps team members begin to think about what their measures of improvement will be, what initial changes they might make, and what level of support they will need.
- 3. Set stretch goals.** A "stretch" goal is one to reach for within a certain time. Setting stretch goals such as "Reduce operating room time by 50% within 12 months" communicates immediately and clearly that maintaining the status quo is not an option. Effective leaders make it clear that the goal cannot be met by tweaking the existing system. Once this is clear, people begin to look for ways to overcome barriers and achieve the stretch goals.
- 4. Avoid aim drift.** Once the aim has been set, the team needs to be careful not to back away from it deliberately or "drift" away from it unconsciously. The initial stretch goal "Reduce operating room time by 50% within 12 months" can slip almost imperceptibly to "Reduce operating room time by 40%" or "by 20%." To avoid drifting away from the aim, repeat the aim continually. Start each team meeting with an explicit statement of aim, for example, "Remember, we're here to reduce operating room time by 50% within 12 months," and then review progress quantitatively over time.
- 5. Be prepared to refocus the aim.** Every team needs to recognize when to refocus its aim. If the team's overall aim is at a system level (for example, "Reduce adverse drug events in critical care by 30% within 12 months"), team members may find that focusing for a time on a smaller part of the system (for example, "Reduce adverse drug events for critical care patients on the cardiac service by 30% within 12 months") will help them achieve the desired system-level goal. Note: Don't confuse aim drift, or backing away from a stretch goal (which usually isn't a good tactic), with consciously deciding to work on a smaller part of the system (which often is a good tactic).

<http://www.ihl.org/knowledge/Pages/HowtoImprove/ScienceofImprovementTipsforSettingAims.aspx>

# Appendix G: AIM Worksheet

As a reminder, this worksheet does not need to be completed prior to your first on-site visit.

## *HealthyHearts NYC Initiative*

### AIM Worksheet

The (health center) \_\_\_\_\_ intends to accomplish (This is a general over-arching statement describing what you intend to accomplish during the time you work on this project – it answers the first question of the Model for Improvement.- “What are we trying to accomplish?” Use the Project AIM as a basis and individualize your AIM statement to reflect the unique needs and resources of your health center or system):

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by (time frame, i.e., month/year in which you intend to accomplish improvement) \_\_\_\_\_ for (what group are you doing this for – what is the target population)

\_\_\_\_\_ because (the rational and reasons to work on this improvement project)

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Specific target goals for improvement for (please specify practice site or entire center) \_\_\_\_\_ are:

- Percentage of
  - CPCI Baseline\*Target Goal:
  
- Percentage of
  - CPCI Baseline\*Target Goal:
  
- Percentage of
  - CPCI Baseline\*
  -Target Goal:
  
- Percentage of
  - CPCI Baseline\*Target Goal:

**Our individual goals include** *(in addition to the project measures and goal, identify specific priority areas you would like to address, based on the results of your initial on-site PF activities, such as:*

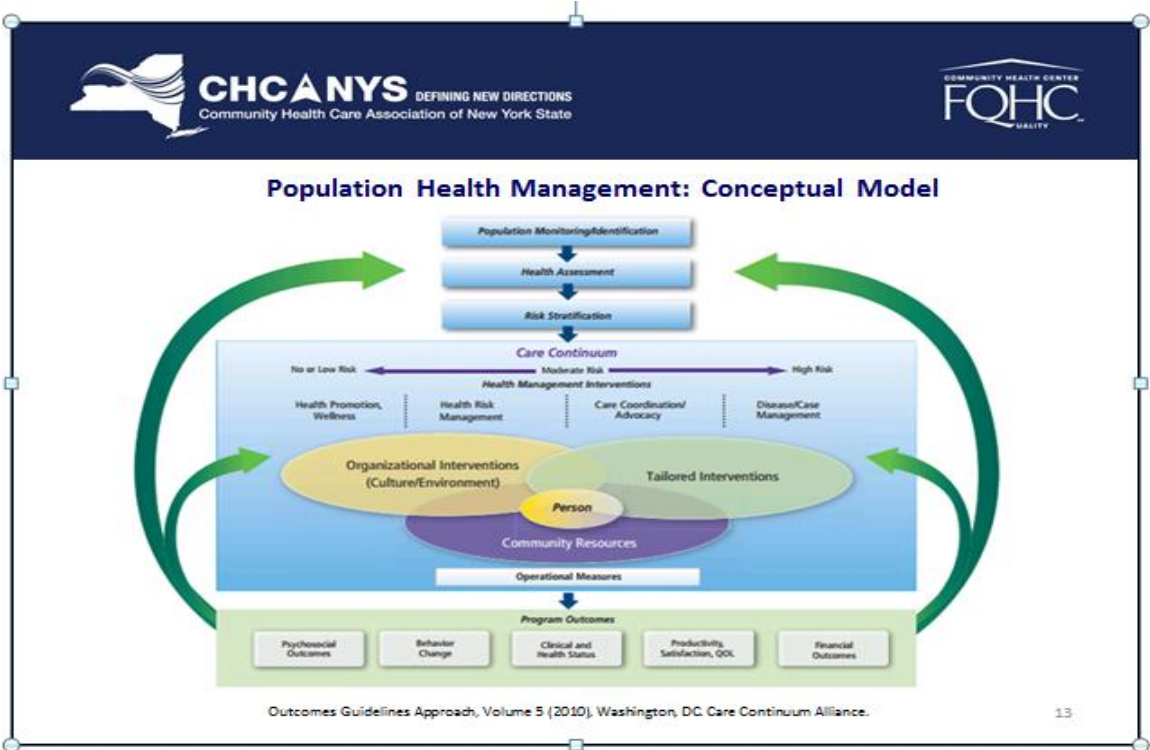
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# Appendix H: Overview of Practice-Based Population Health Management Model

Recognizing the disproportionate investment in illness after it has occurred, health reforms have increasingly aimed to redesign and better invest in interventions that impact behavior patterns, genetic predispositions, social circumstances and environmental exposure in addition to medical care.

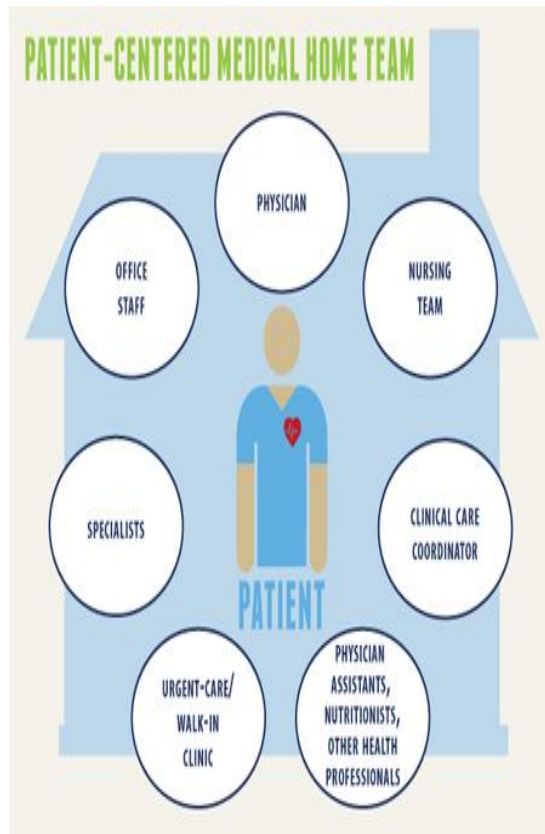
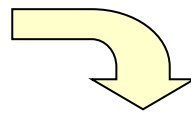
Population Health Management models provide a set of interventions and strategies that continuously and proactively measure and manage a panel of patients, both during and between encounters with the healthcare system. This means that all patients from the lowest risk level to the highest risk level are cared for in the right place, at the right time and in the manner most appropriate for the patient.

Individuals within the population are monitored, assessed and stratified to identify their place on a continuum of health risks, with specific interventions targeted to individuals based on where they fall on the continuum.



# Appendix I: Optimizing Care Teams

In order to enhance care processes and HIT systems, it is imperative for the site to implement and optimize strong, cohesive care teams. As the graphic demonstrates, care teams are foundational in creating and maintaining efficiencies in care, creating greater job satisfaction, and fostering patient-centered care that is empathetic and empowering.



# Appendix J:

## Engaged, Empowered Patients

Sites that embrace an enhanced QI infrastructure with organized care teams thereby enforce engaged and empowered patients. According to AHRQ, such sites do so by:

- Providing empathic, holistic patient-centered care
- Involving the whole care team in planning, implementing, and following up on a patient visit
- Planning patient visits that focus on prevention and care management, and less on urgent, acute care
- Involving the patient in goal setting, and overcoming potential barriers through methods such as motivational interviewing (i.e meeting the patient where they are and working from there)
- Providing tailored education and skills training using materials appropriate for different cultures and health literacy levels
- Making referrals to community-based resources, such as programs that help promote healthy lifestyle (e.g. NDPP)
- Regularly following up with patients via email, phone, text messages, and mailings to support their efforts to maintain healthy behaviors. (Available from [http://www.ora.gov/ahrq/sms\\_what.html](http://www.ora.gov/ahrq/sms_what.html))<sup>i</sup>

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<sup>i</sup> Crosson J, Knox L, McNellis R. Primary Care Facilitation Curriculum. AHRQ Publication (Module 32) No. 15-0060-EF, Rockville, MD, Agency for Healthcare Research and Quality; September 2015.