QUALITY IMPROVEMENT METRIC GUIDE:

QI_004: DEMONSTRATE IMPLEMENTATION OF AND REPORT PROGRESS ON QUALITY IMPROVEMENT ACTIVITY TO INCREASE STATIN USE AMONGST APPLICABLE PATIENT POPULATION.

Cardiovascular Disease Management Project: Evidence-Based Strategies for Disease Management in High-Risk and Affected Populations (Adults Only)

Prepared & Presented By:

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1. PROGRAM OVERVIEW

The OneCity Health DSRIP Cardiovascular Disease Management Project (3.b.i - Evidence-Based Strategies for Disease Management in High Risk/Affected Populations) utilizes evidence-based best practices to manage adults with cardiovascular disease. Cardiovascular disease is a major source of suffering and early death in all populations.

The objective of the Cardiovascular Disease Management Project is to improve the treatment of cardiovascular health in primary care and to support primary care excellence in cardiovascular health in alignment with the Million Hearts Campaign, a national initiative led by the Centers for Medicare and Medicaid Services (CMS) and by the Centers for Disease Control and Prevention (CDC).

- The Million Hearts campaign aims to prevent heart attack and stroke by improving access to effective care, improving the quality of care for the ABCS and by activating the public to lead a heart-healthy lifestyle.
- The Cardiovascular Disease Management project furthers the goals of the Million Hearts Campaign through a variety of strategies to support primary care excellence in cardiovascular health:
  - Aspirin use
  - Blood pressure control
  - Cholesterol management
  - Smoking cessation
  - Support patient self-management of cardiovascular health
  - Promote integrated care delivery, including partnerships with community-based organizations

- Control of cardiovascular disease is a key to helping patients and communities be healthier with:
  - Reduction in potentially avoidable hospital admissions overall,
  - Reduction in potentially avoidable Emergency Department (ED) visits overall,
  - Reduction in hospital admissions related to uncontrolled hypertension or chest pain and
  - Increase in percentage of hypertensive patients whose blood pressure is well controlled. Currently, implementation of the cardiovascular program is active within the outpatient/primary care adult population.

<table>
<thead>
<tr>
<th>Project</th>
<th>Milestone #</th>
<th>Milestone</th>
<th>Completion Quarter</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVD</td>
<td>6</td>
<td>Adopt and follow standardized treatment protocols for Hypertension and elevated Cholesterol.</td>
<td>DY2, Q4</td>
<td>3/31/17</td>
</tr>
</tbody>
</table>
II. 2013 ACC/AHA GUIDELINE ON THE TREATMENT OF BLOOD CHOLESTEROL TO REDUCE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD)

In 2013, the American College of Cardiology (ACC) and the American Heart Association (AHA) released new clinical guidelines on the treatment of blood cholesterol to reduce ASCVD risk in adults. The guidelines from the ACC and AHA recommend statin use among four major statin benefit groups.

The goal of this Quality Improvement Guide is to provide physicians, nurses and clinical team an opportunity to improve in managing their patients with CVD risk to Statin prescribed goals according to the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Disease (ASCVD) risk in Adults.

Using data on current rates of statin therapy for patients in one of the four high ASCVD risk groups, care teams will design a Quality Improvement Process to improve their rates of managing ASCVD risk patients. Tools and resources for improvement will be provided throughout the process.

Both the American College of Cardiology/American Heart Association (ACC/AHA) and National Lipid Association (NLA) emphasize the importance of lifestyle modification as an initial approach to Atherosclerotic Cardiovascular Disease (ASCVD) risk reduction. 1, 2 When therapeutic lifestyle changes alone are inadequate; they recommend the use of Statins as initial pharmacologic therapy for the primary and secondary prevention of ASCVD.

The ACC/AHA and NLA guidelines share definitions for clinical ASCVD (Table 1) and for the intensity of statin therapies (Table 2) derived from doses used in randomized controlled trials (RCTs).1, 2

Statins are first-line agents for the primary and secondary prevention of Atherosclerotic Cardiovascular Disease (ASCVD). Statin intensity and treatment goals should be determined based on presence of ASCVD or ASCVD risk factors.
Applicable Patient Population
Atherosclerotic Cardiovascular Disease (ASCVD)

<table>
<thead>
<tr>
<th>Table 1. Definition of (ASCVD)</th>
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<tbody>
<tr>
<td>Clinical ASCVD is defined as the history of 1 or more of the following morbidities:</td>
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<tr>
<td>• Myocardial infarction/ Acute coronary syndrome</td>
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<tr>
<td>• Stable or unstable angina</td>
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<tr>
<td>• Coronary or other arterial revascularization</td>
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<tr>
<td>• Stroke</td>
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<tr>
<td>• Transient ischemic attack</td>
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<tr>
<td>• Peripheral artery disease presumed to be of atherosclerotic origin</td>
</tr>
</tbody>
</table>

Statin Medication Intensity Therapy

<table>
<thead>
<tr>
<th>Table 2. Intensity of Statin Therapy</th>
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</thead>
<tbody>
<tr>
<td><strong>High</strong></td>
</tr>
<tr>
<td>Daily Dosage ↓ LDL-C ≥ 50%</td>
</tr>
<tr>
<td>Atorvastatin 40-80 mg</td>
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<tr>
<td>Rosuvastatin 20-40 mg</td>
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</table>

Individual responses may vary
BID=twice per day; LDL-C=low-density lipoprotein cholesterol

Statin Benefit Groups

Individuals with clinical atherosclerotic cardiovascular disease (ASCVD) - acute coronary syndromes, or a history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin - without New York Heart Association (NYHA) class II-IV heart failure or receiving hemodialysis.

Individuals with primary elevations of low-density lipoprotein cholesterol (LDL-C) ≥ 190 mg/dL

Individuals 40-75 years of age with diabetes, and LDL-C 70-189 mg/dL without clinical ASCVD.

Individuals without clinical ASCVD or diabetes, who are 40-75 years of age with LDL-C 70-189 mg/dL, and have an estimated 10-year ASCVD risk of 7.5% or higher.
III. DSRIP PHASE III CONTRACTING CARDIOVASCULAR DISEASE METRIC

<table>
<thead>
<tr>
<th>Metric ID - Metric Type</th>
<th>QI_004 - Process</th>
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<tr>
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<td>Demonstrate implementation of and report progress on one (1) quality improvement (QI) activity to increase statin use amongst applicable patient population.</td>
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<td>Participant Obligations</td>
<td>identify one (1) QI activity and report the QI plan and baseline data for the intended cohort. Report performance against the baseline cohort data and provide a progress update.</td>
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</table>

*See Appendix for Phase III OneCity Health Partner Reporting Instructions

IV. ABOUT THIS QUALITY IMPROVEMENT METRIC RESOURCE GUIDE

This Quality Improvement Metric Resource Guide provides a high-level overview of the DSRIP Cardiovascular Disease Management Project, Phase III Contracting Metric QI_004 and how creating Registry Reports can be used to help identify patients with Atherosclerotic Cardiovascular Disease (ASCVD). The overview is meant to provide guidance for you, your practice Electronic Medical Record (EMR) champion, or IT staff.

Experienced users are the main focus of this Guide; not every step is included in the instructions, and this is not a replacement for training from your electronic health record (EMR). There are several ways to approach each workflow in the (EMR). This Guide highlights one workflow; however, you may be familiar with an alternative approach. Please note that Screenshots used in this guide and features may change as new software versions are released.

Using Registry Reports
The Registry Report can be helpful to identify Atherosclerotic Cardiovascular Disease (ASCVD) or Hypercholesterolemia patients meeting certain criteria, including diagnosis, current and prior medications, LDL-C values, and other clinical or patient demographic information.

Report Criteria
Registry Reports can be created from multiple criteria such as lab values, medications, and patient diagnoses. For example, EMR criteria could include patients with clinical ASCVD, being on maximally tolerated Statin therapy atorvastatin 40 mg/day and having elevated LDL-C ≥70 mg/dL or ≥100 mg/dL.

Factors That May Impact Registry Reports
The number of patients appearing on a Registry Report may be impacted by the clinical data available in the EHR; for example, if lab results are saved in the EMR as a PDF file and not available for use as ‘Data’ to be queried. Additionally, in those cases where lab results are received from multiple laboratories, it may be necessary to select each lab’s order codes to enable all appropriate patients to appear on the Registry Report.
Continued

Query results are only based on the specific lab code that is selected. In those cases where there are several different LDL lab options or codes (ex.: LDL Direct, Low Density Lipoprotein, DLDDL, LDL Cholesterol, Direct, Cholesterol, LDL) or where lab results are received from multiple laboratories, it may be necessary to select each lab’s order codes individually to enable all appropriate patients to appear on the Registry Report.

As a best practice, all Health Care Professionals (HCPs) should consistently use the same LDL lab code option so that the query results will encompass all patients within the practice.

The query criteria should consider active patients only (not deceased or inactive, as determined by the practice). Also, medications prescribed before the EHR was implemented might not be included in a patient’s medications list. These information gaps can reduce the number of patients on a Registry Report.

Developing Registry Reports helps to facilitate and support continuous quality improvement.

V. REPORTING: CREATING A REGISTRY REPORT

A Patient List, called Registry Reports, is an Electronic Health Record system report that identifies all patients meeting certain criteria. Available criteria include diagnosis, current and prior medications, lab values, and other clinical or patient demographic information.

The following steps illustrate how to run a Registry Report to help identify patients with Atherosclerotic Cardiovascular Disease (ASCVD) and their prescribed Statin medications.
The following demonstrates how to run reports based upon criteria in eClinicalWorks EHR.

A. Criteria Example: Create Registry

2. To create a Registry Report, select **Registry** from the left navigation menu and then select the Large R for Registry

3. Navigate to the **Labs / DI /Proc** tab

4. Click **Sel** to select the test from the list of available labs

Use Registry Reporting To:
- Provide information about the practice’s entire patient population.
- Search the entire patient database for medical or relevant information.
  - For example: the number of patient encounters, patients with a particular medical condition, vital records, medical history, or labs

B. Criteria Example: Create Registry Report
C. Criteria Example: Registry Patient List Query - Atherosclerotic Cardiovascular Disease (ASCVD)

1. Select the **ICD tab** in the center of the screen and then Select **Filters** to search for appropriate diagnosis codes Clinical ASCVD [e.g. stroke, transient ischemic attack, acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, peripheral arterial disease] plus hypercholesterolemia

2. **Click OK** when done.

3. **Select Date Range**
D. Criteria Example: Further stratify by patients who have been prescribed a particular medication, class of medication or multiple medications

- Click **Run New**.
- **Select the Rx tab** Select Drug Class, and then click the **Sel button** to find a specific class of medications.

- From **RX dropdown**, select **Contains** and enter drug class; i.e., **Statin**.

  Highlight the **desired medication(s)** A list of the medication(s) will display (e.g., atorvastatin, rosuvastatin), Select the medication name and dose for which you want to run a report

- **Click OK** after you select the drug
5. Make sure the search is defaulted to CURRENT MEDICATION AS OF TODAY

6. Select RUN SUBSET. Or, select Run Subset (NOT) to identify patients with ASCVD and not on a specific medication

Additional Filters

1. Select Lab/Di/Proc tab, select appropriate lab test and result values (i.e., LDL-C ≥ 70 mg/dL or ≥ 100 mg/dL, depending on insurance). Click OK and click Run Subset.

2. Save Registry Reports for future use by clicking Save Queries.

3. Further stratify by patients who have been prescribed a particular medication, class of medication or multiple medications

To Export Data:
Select ANALYZE → Copy → open Excel file, close blank pop-up window, and Excel file will open
VI. QUALITY IMPROVEMENT SUPPORT: AIMS AND MEASURES

The Aims and Measures section is intended to provide protocol users with a menu of measures for multiple purposes that may include the following:

- Population health improvement measures,
- Quality improvement measures for delivery systems,
- Measures from regulatory organizations such as Joint Commission,
- Measures that are currently required for public reporting,
- Measures that are part of Center for Medicare Services Physician Quality Reporting initiative, and
- Other measures from local and national organizations aimed at measuring population health and improvement of care delivery.

Criteria Example: Aims ad Measures

Increase the percentage of patients with or at high risk for atherosclerotic disease that are on Statin therapy.

Measures for accomplishing this aim:

a. Percentage of patient’s ≤ 75 years of age who have clinical ASCVD and are prescribed statin therapy.

b. Percentage of patient’s ≥ 18 years of age with primary LDL-C ≥ 190 mg/dL who are prescribed statin therapy.

c. Percentage of patient’s ages 40 to 75 years with diabetes, LDL-C 70-189 mg/dL and are prescribed statin therapy.

d. Percentage of patients ages 40 to 75 years without clinical ASCVD or diabetes, LDL-C 70-189 mg/dL and a calculated 10-year CVD event risk > 7.5% and are prescribed statin therapy.

Exclusion for measurements a, b, and d: Patient’s for whom there is documentation that statin therapy is contraindicated or not tolerated, including those who are pregnant or at risk for pregnancy.

Criteria Example: Measure Specification

Measurement a

- Percentage of patient’s ≤ 75 years of age who have clinical ASCVD and are prescribed statin therapy.

Population Definition

- Patient’s ≤ 75 years of age who have clinical ASCVD.

- Exclusion for measurements a, b, and d: Patients for which there is documentation that statin therapy is contraindicated or not tolerated, including those who are pregnant or at risk for pregnancy.

Data of Interest

| # of patients prescribed statin therapy |
| # of patient’s ≤ 75 years of age who have clinical ASCVD |

(Myocardial Infarction/ Acute Coronary Syndrome; Stable or Unstable Angina; Coronary or other Arterial Revascularization, Stroke; Transient Ischemic Attack; Peripheral Artery Disease presumed to be of Atherosclerotic origin)

Method/Source of Data Collection

Review EMR for patients meeting criteria in the denominator and determine the number of patients meeting Patient the numerator criteria.
Note:
This is a Process Measure, and improvement is noted as an increase in the rate.
• Process Measures are a measurement of compliance with a specific procedure.
• Process measures can supply actionable feedback by illuminating if the prescribed procedure, protocol or guideline is being followed consistently.

Process Measures: (Voice of the Workings of the System)
• Are key changes linked to an outcome?
  » Example: Patients who smoke receive cessation counseling which in turn reduced the risk of stroke and/or heart attack
• Are the parts/steps in the system performing as planned?
• Are key changes being implemented in the system?
• What is the system telling you about how well it is working?

VII. CRITERIA SAMPLE: AIM STATEMENT
“To increase appropriate intensity Statin prescription as specified in the 2013 ACC/AHA guidelines, in all primary care patients with Atherosclerotic Cardiovascular Disease (ASCVD) or Diabetes Mellitus (DM), with an aim to make a 25% relative improvement from baseline January 2017 to January 2019”.

VIII. CRITERIA EXAMPLE – RESEARCH ARTICLE ABSTRACT
Abstract 142: Increasing Appropriate Statin Use in the Primary Care Clinic
Circulation: Cardiovascular Quality and Outcomes. 2017;10: A142
Aditya K Khetan, Omer Khan, Umar Rashid, Christopher Pleyer, Mamta Singh

Abstract
Background: In 2013, ACC/AHA released new guidelines for cholesterol management. Historically, new guidelines can take up to a decade to diffuse into clinical practice, leading to suboptimal patient management. We hypothesized that systematic identification of barriers, and targeted interventions can improve management of cholesterol.

Objectives: To increase appropriate intensity statin prescription, as enumerated in the 2013 ACC/AHA guidelines, in all primary care clinic patients with atherosclerotic cardiovascular disease (ASCVD) or diabetes mellitus (DM), with an aim to make a 25% relative improvement from baseline (Dec’14) to Dec’ 15.

Methods: Information regarding statin use was obtained from the primary care clinic database. MD, NP and PharmD providers in the clinic were surveyed with an aim to understand the barriers to prescribing statins. A series of tailored interventions was subsequently deployed through multiple PDSA cycles, including pocket cards on statin guidelines, education sessions and EMR generated lists of patients who were not on a statin as per guidelines.

Result: Baseline data showed that 59.7% (238 of 398) patients with ASCVD were on an appropriate dose statin, while 70.7% (619 of 875) patients with DM were on an appropriate dose statin. Post intervention results after 12 months showed a 8.4% relative increase (258 of 398) in appropriate dose statin use amongst patients with ASCVD and a 2.1% relative increase (632 of 875) in patients with DM.

Conclusions and Implication: A targeted strategy of PDSA cycles can increase the rates of statin usage, and lead to quicker uptake of ACC/AHA guidelines on cholesterol management.
IX. PLAN-DO-STUDY- ACT (PDSA) CYCLES OF CHANGE

Plan, Do, Study, Act (PDSA) Cycles

The Plan-Do-Study-Act (PDSA) cycle is part of the Institute for Healthcare Improvement Model for Improvement, a simple yet powerful tool for accelerating quality improvement. Once a team has set an aim, established its membership, and developed measures to determine whether a change leads to an improvement, the next step is to test a change in the real work setting. The PDSA cycle is shorthand for testing a change—by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning.

The steps in the PDSA cycle are:

**Step 1:** Plan—Plan the test or observation, including a plan for collecting data

**Step 2:** Do—Try out the test on a small scale

**Step 3:** Study—Set aside time to analyze the data and study the results

**Step 4:** Act—Refine the change, based on what was learned from the test

**PDSA worksheet for testing change - TEMPLATE**

### AIM

PDSA Cycle # 1
(Every Aim will require multiple small tests of change)

<table>
<thead>
<tr>
<th>Describe your test of change:</th>
<th>Person(s) Responsible</th>
<th>When to complete</th>
<th>Where to complete</th>
</tr>
</thead>
</table>

### PLAN

List the tasks needed to set up this test of change

| 1. | Person(s) Responsible | When to complete | Where to complete |
| 2. | | | |
| 3. | | | |

**Predict what will happen when the test is carried out**

| Indicator to measure if prediction succeeds |

### DO

Describe what actually happened when you ran the test.

### STUDY

Describe the measured results and how they compared to the predictions.

### ACT

Describe what modifications to the plan will be made for the next cycle from what you learned.
X. PERFORMANCE IMPROVEMENT CONTINUING MEDICAL EDUCATION (CME)

If you are a physician, accredited CME provider or have questions about the Performance Improvement Continuing Medical Education (PI CME) or Maintenance of Certification (MOC) learning format, the information presented in this guide is in accordance with American Medical Association (AMA), American Board of Family Medicine (ABFM) OR American Board of Internal Medicine (ABIM).

A. Criteria Example: Accredited CME Provider PI Project
See Resources for CME details.

B. Accredited CME Provider Learning Objectives

Learners participating in this activity will:

1. Examine current processes for identifying patients within their practice who are high risk for ASCVD based on the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Disease (ASCVD) risk in Adults and the ASCVD risk calculator

2. Identify opportunities to improve clinical care processes

3. Apply appropriate interventions for those patients identified as ASCVD high risk

4. Execute revised strategies to improve clinical care processes

C. Criteria Example: AMA Format Specific Requirements

Consist of the following 3 stages:

- **Stage A: Learning from Current Practice Performance Assessment**
  Assess current practice using the identified performance measures, either through chart reviews or some other appropriate mechanism.

- **Stage B: Learning from the Application of PI to Patient Care**
  Implement the intervention(s) based on the results of the analysis, using suitable tracking tools. Participating physicians should receive guidance on appropriate parameters for applying the intervention(s).

- **Stage C: Learning from the Evaluation of the PI CME Effort**
  Re-assess and reflect on performance in practice measured after the implementation of the intervention(s), by comparing to the original assessment and using the same performance measures. Summarize any practice, process and/or outcome changes that resulted from conducting the PI CME activity.
XI. APPENDIX

<table>
<thead>
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<th>Metric ID – Metric Type</th>
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<tr>
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</tr>
<tr>
<td></td>
<td>Report performance against the baseline cohort data and provide a progress update.</td>
</tr>
</tbody>
</table>

REPORTING INSTRUCTIONS

There are four due dates for this metric:

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Report due date:</th>
<th>Reporting time period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI_004.1</td>
<td>April 30, 2018</td>
<td>Baseline Period</td>
</tr>
<tr>
<td>QI_004.2</td>
<td>July 31, 2018</td>
<td>April 1, 2018 – June 30, 2018 or Baseline Period (if baseline was not previously reported for QI_004.1)</td>
</tr>
<tr>
<td>QI_004.3</td>
<td>October 31, 2018</td>
<td>July 1, 2018 – September 30, 2018</td>
</tr>
<tr>
<td>QI_004.4</td>
<td>January 31, 2019</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>

Measure description: Patients 18 years of age and older with CVD risk prescribed Statin therapy to goals according to the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Disease (ASCVD) risk in Adults. Use data on current rates of Statin therapy for patients in one of the following high ASCVD risk groups:

1. Individuals with clinical ASCVD
2. Individuals with primary elevations of LDL-C ≥190 mg/dL
3. Individuals 40-75 years of age with diabetes, LDL-C 70-189 mg/dL
4. Individuals 40-75 years of age without clinical ASCVD or diabetes, LDL-C 70-189 mg/dL and >7.5% estimate 10-year ASCVD risk.

Quality improvement activity description: The quality improvement activity should collect and analyze data from available data sources and test changes/interventions to achieve improvement goals related to the indicator as described.
Instructions for reporting on this metric are included below. All information will be entered into the Portal. The submission should be completed at a system level.

The first report submission should be for baseline performance on the quality improvement (QI) activity to increase Statin use amongst the applicable population and include the following:

• **Aim:** Describe and/or upload the quantitative and/or qualitative goal(s) of your quality improvement activities and how the improvement intervention will increase Statin use

• **Baseline Performance:** Describe and/or upload the baseline performance period and quantitative and/or qualitative measurement results related to the goal(s). The baseline performance period should include at a minimum a six month period after October 1, 2016. If baseline measurement results are not available, please describe the plan to establish a baseline measurement by the following reporting period.

• **Data Source:** Describe and/or upload the data source(s) that will be used to measure performance

Please note that the baseline performance submission will only be accepted for QI_004.1 or QI_004.2, if baseline submission is missed for QI_004.1.

Subsequent report submissions should be progress updates for performance against the baseline on follow-up activity to increase Statin use amongst the applicable population and include the following:

• **Reporting Period Performance:** Describe and/or upload the quantitative and/or qualitative measurement results related to the goal(s) during the reporting time period

• **Action:** Describe and/or upload actions during the reporting time period taken to improve selected goal(s) described during the baseline performance period and the outcomes of these actions

All partners may be subject to audit.
XII. REFERENCES


OneCity Health | NYC Health + Hospitals (February 2018). Phase III OneCity Health Partner Reporting Manual. QI_004 – Process: Demonstrate implementation of and report progress on one (1) quality improvement (QI) activity to increase statin use amongst applicable patient population, pages 60-61

OneCity Health | NYC Health + Hospitals (January 2018). CARDIOVASCULAR HEALTH IN PRIMARY CARE: PHASE 3 IMPLEMENTATION TOOLKIT FOR COMMUNITY PARTNERS.


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