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 establishes seven regional cooperatives composed of public and private health partnerships that will 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: Aspirin in high-risk individuals, Blood pressure control, Cholesterol management, and Smoking 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.

**Midwest Cooperative**

**Cooperative Name:** Healthy Hearts in the Heartland

**Principal Investigator:** Abel N. Kho, M.D., M.S., Northwestern University

**Cooperative Partners:**
- Northwestern University ([Chicago Regional Extension Service (REC))
- Alliance of Chicago Community Health Services
- American Medical Association
- Illinois Department of Public Health
- MetaStar, Inc. (Wisconsin REC)
- Telligen, Inc. (Illinois Quality Improvement Organization [QIO])
- Northern Illinois University (Illinois REC)
- Northwestern Memorial Physicians Group
- Purdue University (Indiana REC)
- University of Chicago

**Geographic Area:** Illinois, Wisconsin, Indiana

**Project Period:** 2015-2018

**Region and Population**

The project region encompasses southeastern Wisconsin, northeastern Illinois (including Chicago), and northern Indiana, a highly diverse population of more than 16 million people. Cardiovascular risk factors are prevalent: 31.2 percent have high blood pressure, 29.3 percent are considered obese, 38.1 percent have high cholesterol levels, and 20.5 percent are current smokers. In addition, 34 percent of these patients live in areas designated by the Health Resources and Services Administration as Medically Underserved Areas or are part of Medically Underserved Populations and may have limited access to primary care.

**Specific Aims**

1. Evaluate the ability of small practices in the region to a) implement point-of-care and population management quality improvement strategies to improve the ABCS of cardiovascular disease prevention, and b) implement performance measurement software to evaluate performance on the ABCS and allow regional benchmarking.
2. Conduct a practice-randomized trial to determine whether point-of-care strategies improve ABCS performance measures compared to baseline, and whether adding locally-tailored population management strategies to point-of-care strategies improves performance on the ABCS measures more than point-of-care strategies alone.
3. Deploy an open-source quality measurement platform (PopHealth) to establish a regional quality improvement benchmark based on participating practice ABCS measures and to enable longitudinal tracking of electronic clinical quality measures across the region.

**Reach**

- Goal for Number of Primary Care Practices Recruited: 250-325
- Goal for Number of Primary Care Professionals Reached: 750-975
- Goal for Population Reached: 1.13-1.46 million
Comment from Principal Investigator

Abel Kho, M.D., M.S.

“Over the past five years, our team and partners in the Tri-State (Illinois, Wisconsin, and Indiana) region have helped primary care practices, particularly small- or medium-sized independent practices, move from paper to Electronic Health Records (EHRs). This transformation has presented our primary care providers with new opportunities, for example, to use their EHRs to objectively track and improve the quality of care they provide, or to engage their patients in self-care. But we’ve also seen current market forces drive practice consolidation because smaller practices often lack the resources and infrastructure to engage in quality improvement initiatives or the size to negotiate sustainable reimbursements. Our project aims to bring together a motivated team of regional collaborators to explore, develop, and disseminate data and population health-driven strategies to help primary care practices maintain their independence and deliver high-quality, well-coordinated, and sustainable health care, with a primary focus on the ABCS of cardiovascular disease prevention.”

Notable Project Features

- Partnerships with four Regional Extension Centers, State departments of health, quality improvement organizations, and the American Medical Association
- Use of community linkages with pharmacies (CVS, Walgreens) and smoking cessation quit lines
- Combined individual patient and population health approaches

Approach and Methods

Practice Recruitment and Enrollment

Over the first year, the Cooperative will recruit by:

- Using in-person meetings, phone calls, direct mailings, faxes, and emails customized to local practices
- Leveraging relationships within social networks of practice facilitators and engaging with local communities and stakeholders

Support Strategy

The Cooperative will help practices improve the quality of care and adoption of the ABCS through individual point-of-care and population management strategies:

- Point-of-care strategies that focus on improving the quality and efficiency of care delivered to individual patients during office visits. These strategies will include educational tools and electronic reminders to enhance aspirin prescription and cholesterol management;
- Population management strategies that use systems-based approaches to improve population health. These strategies will include creating lists of patients eligible for aspirin or cholesterol interventions so that practices can conduct direct outreach, developing partnerships with community pharmacists to enhance team-based blood pressure care, and connecting documented smokers to local quit lines and other telephone-based smoking cessation counseling.
- Learning Collaborative. The Learning Collaborative will offer multiple opportunities for practice facilitators and participating practices to engage in shared learning:
  - Monthly training Webinars
  - Access to national and regional quality improvement experts
  - Monthly site visits by practice facilitators or other content experts
  - A listserv for information-sharing and problem-solving
  - Access to quality improvement tools and resources

Evaluation

The Cooperative will use a stepped-wedge design that includes a two-arm, cluster randomized comparative effectiveness trial. In this design, care sites are enrolled into the control group and then randomly assigned to the intervention at intervals, with all sites eventually receiving the intervention. Practices will be assigned to point-of-care strategies alone, population management strategies alone, or a combination of both strategies. PopHealth software will be provided to enhance practices’ ability to evaluate their performance on implementing ABCS measures.

Strategies for Disseminating Study Findings and Lessons Learned

The Cooperative will disseminate findings by creating a brand for the initiative; developing brand-focused educational and communications materials distributed through partner networks, a Web site, and social media outlets; and through scientific publications and presentations.


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