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.

**North Carolina Cooperative**

**Cooperative Name:**
Heart Health Now! Advancing Heart Health in NC Primary Care

**Principal Investigator:**
Samuel Cykert, M.D., University of North Carolina at Chapel Hill

**Cooperative Partners:**
University of North Carolina at Chapel Hill
North Carolina Healthcare Quality Alliance
Community Care of North Carolina, Inc.
North Carolina Area Health Education Centers Program

**Geographic Area:**
North Carolina

**Project Period:**
2015-2018

**Region and Population**
North Carolina’s population of nearly 10 million is racially and ethnically diverse, with 72 percent White, 22 percent African American, and 9 percent Hispanic.¹ The burden of cardiovascular disease (CVD) in the State is large, and almost one-third of deaths are caused by CVD (the CVD mortality rate is 263 per 100,000).² CVD risk factors are common among the population; 65 percent of adults are obese/overweight, 32 percent are hypertensive, nearly 10 percent are diabetic, 20 percent smoke, and 54 percent do not meet physical activity targets.³ Only half of patients treated for hypertension currently have their blood pressure under control, and only half of patients aged 40 to 64 with elevated cholesterol have been treated to recommended levels.⁴

**Specific Aims**
Evaluate the effect of primary care practice support on:
1. Evidence-based CVD prevention
2. Patient-level health outcomes
3. Implementation of clinical practice and office systems changes to improve evidence-based CVD prevention
4. Practice capacity to implement new patient-centered outcomes research (PCOR) findings

**Reach**
- **Goal for Number of Primary Care Practices Recruited:** 250-300
- **Goal for Number of Primary Care Professionals Reached:** 750-900
- **Goal for Population Reached:** 1.13-1.35 million
Comment from Principal Investigator
Samuel Cykert, M.D.

“I’ve cared for many people throughout my career who suffered the debilitating effects of a heart attack or stroke way too early. Because of the lack of sophisticated information systems and processes that could quickly identify risk and prioritize new evidence for care, many of these folks missed opportunities that could have prevented the paralysis, shortness of breath, and death that often resulted from premature disease. Despite solid progress over the last few years, small primary care practices often lack the in-house infrastructure and technical expertise to rapidly apply new evidence and new principles to specific populations at high risk. This problem is especially important in cardiovascular disease, the leading cause of death in North Carolina. By partnering with these practices to build in the needed supports, we have the potential to prevent thousands of heart attacks, strokes, and deaths within a few short years. This kind of approach is what a learning health system needs to be about, and I’m thrilled to work with colleagues in practice across the State to achieve that dynamic in healthcare.”

Notable Project Features
- Use of Area Health Education Centers for practice support
- Linkage of small independent practices to an electronic health information exchange infrastructure with centralized analytic and reporting functions
- Emphasis on including practices that serve low-income, rural, and underserved populations

Support Strategy
All practices will receive 12 months of intense practice support, including onsite quality improvement facilitation, academic detailing, electronic health record, and health information exchange support. Components of the practice support will include:

- Optimizing the use of the electronic health record to extract clinical quality data on a monthly basis to guide the change process
- Developing patient registries to identify needed care and outliers from the practices’ patient population
- Promoting use of decision support tools and templates to support practice workflow
- Encouraging proactive, team-based care with assigned roles and responsibilities to help providers engage patients throughout the entire visit process
- Implementing evidence-based protocols and clinical algorithms to encourage the use of standing orders and clinical decision support tools in the electronic health record
- Enhancing self-management support for patients within the practice and developing a strong process of referral to external patient support resources

Evaluation
The Cooperative will use a stepped-wedge, stratified, cluster randomized trial. Each practice will start the trial as a control, receive the intervention at a randomized point in time, and then enter a maintenance period 12 months after starting the intervention.

Strategies for Disseminating Study Findings and Lessons Learned
The Cooperative will disseminate findings through community forums, local media outlets, social media, scientific meetings and presentations, and outreach to partners and stakeholders.


Last updated date: May 13, 2015