

North Carolina 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 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: **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:

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 Hispanic¹. 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



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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

Approach and Methods

Practice Recruitment and Enrollment

During the first 3 months of the project, the Cooperative will recruit small and medium-sized practices that are, or have agreed to be, connected to the Community Care of North Carolina (CCNC) Informatics Center. The Informatics Center is a shared statewide service in which providers can share patient health information and access reporting dashboards to support chronic disease and preventive care, including performance tracking to support rapid-cycle quality improvement and identification of care gaps at the patient level. The shared data infrastructure allows researchers to conduct population-wide analyses, create benchmarks, and evaluate the impact of quality improvement interventions. Use of the CCNC Informatics platform creates an external reporting mechanism that otherwise would not be available to independent practices, particularly those in rural and underserved areas. The Cooperative will recruit primarily through members' existing relationships with practices throughout the State.

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.

¹ <http://quickfacts.census.gov/qfd/states/37000.html>. Accessed April 26, 2015.

² <http://www.americashealthrankings.org/NC/CVDDeaths/2012>. Accessed April 25, 2015.

³ North Carolina Department of Health and Human Services. *Health Profile of North Carolinians 2011 Update*; 2014.

⁴ Yoon SS, Ostchega Y, Louis T. Recent trends in the prevalence of high blood pressure and its treatment and control, 1999-2008. *NCHS Data Brief 2010 Oct;48:1-8*. PMID: 21050532.