EvidenceNOW
Advancing Heart Health in Primary Care

Oklahoma 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:
Healthy Hearts for Oklahoma (H2O)

Principal Investigator:
F. Daniel Duffy, M.D., University of Oklahoma Health Sciences Center

Cooperative Partners:
University of Oklahoma Health Sciences Center

Public Health Institute of Oklahoma

Community Service Council of Greater Tulsa

Oklahoma Primary Care Association

Oklahoma Center for Healthcare Improvement

National Resource Center for Academic Detailing

Oklahoma Foundation for Medical Quality

Brigham and Women's Hospital

Geographic Area:
Oklahoma

Project Period:
2015 2018

Region and Population

Oklahoma has a population of 3.85 million, of which 75.5 percent is White, 7.6 percent is African American, 9.0 percent is Native American, 1.9 percent is Asian, and 9.3 percent is Hispanic.[1] Oklahoma's health statistics are among the worst in the Nation, with cardiovascular disease (CVD) as the most frequent cause of premature death. Within the state, 23.3 percent of residents are current smokers, 35.5 percent have hypertension, 31.1 percent are physically inactive, and 32.2 percent are obese.[2]

Specific Aims

1. Construct an effective, sustainable Oklahoma Primary Healthcare Improvement Center (OPHIC) that can serve as a resource to the emerging Oklahoma Primary Healthcare Extension System (OPHES), supporting dissemination and implementation of patient-centered outcomes research findings into practices.
2. Provide technical support to 300 primary care practices to help them implement patient-centered outcomes research-based methods to improve their management of patients at risk for CVD events, especially methods such as smoking cessation, blood pressure control, statins, and low-dose aspirin.
3. Evaluate the impact of the intervention's support strategy and of contextual factors, such as practice characteristics, on practice performance and outcomes.

Reach

- Goal for Number of Primary Care Practices Recruited: 270-300
- Goal for Number of Primary Care Professionals Reached: 810-900
- Goal for Population Reached: 1.23-1.35 million

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Comment from Principal Investigator

Daniel Duffy, M.D.

"The Oklahoma Primary Healthcare Improvement Cooperative (OPHIC) is a new model of practice-based learning and improvement that brings research findings and innovations into the workflow of primary care practices. The OPHIC plan will make available physician coaches (academic detailers), information technology advisors (Regional Extension Center technicians), and in-practice facilitators (practice enhancement assistants) who will manage the change process, data, and role and responsibility changes in the practice.

The OPHIC is one component of the larger Oklahoma Primary Healthcare Extension System, which is building an infrastructure of primary care practices, county-level public health and community action services, the public sector, and business community into a County Health Improvement Organization (CHIO). The CHIO will bring community-level expertise and resources to assist primary care physicians in meeting their targets for prevention of cardiovascular disease.

A further unique feature of this project is the incorporation of the two Health Information Exchange Organizations (HIEOs) in Oklahoma (MyHealth and Coordinated Care Oklahoma) to provide practice-level quality reports on cardiovascular disease prevention and improvements in utilization and patient outcomes. The analytics services provided by the HIEOs can be used to automate data collection and reporting in a seamless fashion for quality improvement and for research in measuring the outcomes and characteristics of practices across the state."

Notable Project Features

- Emphasis on reaching practices that serve Native American, rural, and underserved populations
- Connection of each participating practice to one of the two State Health Information Exchange Organizations
- Large number of small- and medium-sized practices in the State

Approach and Methods

Practice Recruitment and Enrollment

Over the first 6 months of the project, the Cooperative will recruit practices primarily by working through State professionals associations, health systems, and Health Information Exchange Organizations leveraging Cooperative members' existing relationships with practices, and enlisting the help of county health improvement organizations.

Support Strategy

Each participating practice will receive a 1-year intervention consisting of:

- Baseline and monthly *performance feedback and coaching*. Lessons learned from high performing practices will be disseminated to all practices to help them improve performance.
- *Academic detailing visits* with practice clinicians and staff that involve conversations about findings from evidence, what the practice is currently doing, and lessons learned from high performing practices. These conversations will lead to a quality improvement plan.
- *Practice facilitation*, in which practice enhancement assistants become temporary members of the practices, acting as change agents to facilitate tailored solutions though plan-do-study-act quality improvement cycles.
- *Information technology support* to help practices make more effective use of their electronic health records and the state's Health Information Exchange services.
- Participation in a collaboration *Web site and listserv* to support ongoing quality improvement.
- *Community-level interventions* in selected counties to encourage patients to address CVD risk factors.

Evaluation

The Cooperative will use a geographic stepped-wedge design, in which practices are randomized by county and stratified by geographic quadrant to 4 waves of 75 practices, each wave beginning 3 months after the previous wave. A second randomization will assign practices to work first on either
1) smoking cessation and blood pressure control, or
2) lipid management and low-dose aspirin,
switching to the other two after 6 months.

Strategies for Disseminating Study Findings and Lessons Learned

The Cooperative will disseminate findings through a project information booth at professional association conferences, articles in local community publications, a collaboration Web site and a listserv, and articles in scientific journals.

[1] *http://quickfacts.census.gov/qfd/states/40000.html. Accessed April 26, 2015.*

[2] *http://www.healthyamericans.org/states/?stateid=OK. Accessed April 26, 2015.*

Last updated date: May 14, 2015