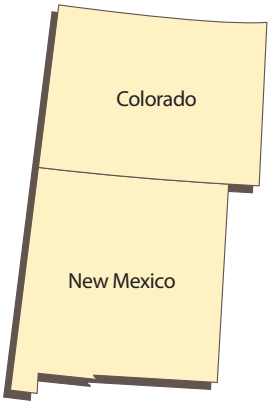
EvidenceNOW
Advancing Heart Health in Primary Care

Southwest 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:
Evidence Now Southwest

Principal Investigator:
W. Perry Dickinson, M.D.,
University of Colorado at Denver

Cooperative Partners:
University of Colorado at Denver

University of New Mexico Health Sciences Center

Colorado Health Extension System

New Mexico Health Extension Rural Offices

Colorado Foundation for Public Health and Environment

Geographic Area:
Colorado and New Mexico

Project Period:
2015-2018

Region and Population

Colorado and New Mexico have a combined population of 7.3 million people. The States are racially and ethnically diverse, with substantial Hispanic (Colorado: 21%; New Mexico: 47%) and Native American (Colorado: 1.6%; New Mexico: 10%) populations.[1] The burden of cardiovascular disease (CVD) and related conditions is very high. In each state, about 20 percent of adults die of heart disease and 5 percent from stroke, 21 percent have high blood pressure, 34 percent have high blood cholesterol, 6 to 7 percent have diabetes, and more than half are overweight or obese.[2,3]

Specific Aims

1. Build primary care practice capacity for quality improvement, change management, and implementation of patient-centered outcomes research findings in small- and medium-sized primary care practices in Colorado and New Mexico.
2. Conduct a cluster randomized trial with an external matched cohort control group using the RE-AIM model (Reach, Effectiveness, Adoption, Implementation, and Maintenance) to examine two practice transformation approaches to improve cardiovascular risk in primary care patients.
   - **a.** Examine the impact of a *standard practice transformation support intervention*.
   - **b.** Determine the incremental benefit of adding *patient engagement* activities.
3. Identify key practice characteristics and other contextual factors that affect the response of practices to the two interventions.
4. Disseminate the findings to key local, regional, and national stakeholders, including sharing ongoing lessons learned and resources.

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Reach

- Goal for Number of Primary Care Practices Recruited: 250-260 (208 in Colorado, 52 in New Mexico)
- Goal for Number of Primary Care Professionals Reached: 750-780
- Goal for Population Reached: 1.13-1.17 million

Comment from Principal Investigator

Perry Dickinson, M.D.

"Evidence Now Southwest will allow for two separate but related efforts in Colorado (the Colorado Health Extension System) and New Mexico (Health Extension Rural Offices) to build on their existing strengths by learning from each other and to further extend their support of practice transformation and community health improvement efforts across our two States. The project will also allow us to test the impact of patient engagement on practice transformation efforts."

Notable Project Features

- Rural mountain States
- Focus on patient engagement in the practice transformation process in selected practices
- Use of the Boot Camp Translation process, in which practices and patients collaborate to translate best practices into culturally- and community-relevant terms

Approach and Methods

Practice Recruitment and Enrollment

During the first 2 years of the project, the Cooperative will recruit practices, primarily through its members' existing relationships with practices, practice organizations, and practice support organizations.

Support Strategy

Each participating practice will receive 9 months of support consisting of:

- An *academic detailing* visit to share information about the project and gain buy-in from practices
- A *practice assessment* to determine the practice's culture, recent or ongoing practice transformation efforts, and current use of patient-centered medical home concepts
- *Health information technology assistance* to help practices develop data capacity for quality measures and population management and to link practices with a central data aggregation system for quality measures
- Active *practice facilitation* consisting of regular meetings with a practice improvement team
- Participation in two *regional learning collaborative* sessions
- Access to *e-learning modules*

Selected practices also will receive an enhanced practice transformation intervention consisting of:

- A *boot camp translation process*, which will use practice and patient suggestions to modify a basic CVD toolkit for local environments
- A *patient advisory council* to help ensure that practices' quality improvement efforts are both transformational and patient-centered

Evaluation

The Cooperative will use a two-arm, cluster-randomized trial with four randomization cohorts and an external matched cohort control group. The evaluation will assess the impact of standard patient engagement and enhanced practice transformation interventions on primary care-based strategies to improve management of CVD risk.

Strategies for Disseminating Study Findings and Lessons Learned

The Cooperative will disseminate findings through presentations and publications for scientific, clinical, and public health and health policy audiences; detailed implementation guides and lessons learned documents; and customizable materials available through the project and Cooperative member Web sites.

[1] *http://quickfacts.census.gov/qfd/states/35000.html. Accessed April 26, 2015.*

[2] *http://www.cdc.gov/chronicdisease/states/pdf/colorado.pdf. Accessed April 26, 2015.*

[3] *http://www.cdc.gov/chronicdisease/states/pdf/new_mexico.pdf. Accessed April 26, 2015.*

Last updated date: May 21, 2015