



Virginia 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 of Virginia Healthcare

Principal Investigator:

Anton Kuzel, M.D., M.H.P.E.,
Virginia Commonwealth University

Cooperative Partners:

Virginia Commonwealth University

Virginia Center for Health
Innovation

VHQC

George Mason University

Center for Health Policy
Development

Geographic Area:

Virginia

Project Period:

2015-2018

Region and Population

Virginia has a population of more than 8.1 million people.¹ Heart disease is the second leading cause of death. Although most of these deaths occur in the populous urban and suburban centers in Northern, Central, and Eastern Virginia, some of the highest age-adjusted death rates due to heart disease can be found in less populous rural areas, including medically underserved areas. Cardiovascular disease (CVD) risk factors are prevalent: 62 percent of adults are overweight or obese, 35 percent have high cholesterol, 30 percent have high blood pressure, 19 percent are smokers, 9 percent have diabetes, and 48 percent do not meet physical activity recommendations.² Like the Nation as a whole, Virginia experiences racial, ethnic, and economic disparities in access to care and effectiveness of care for CVD.^{3,4}

Specific Aims

1. Accelerate the incorporation of patient-centered outcomes research clinical and organizational findings into practice, with an initial focus on cardiovascular health and ABCS.
2. Increase practices' capacity to integrate new patient-centered outcomes research findings on an ongoing basis.
3. Help practices learn strategies to sustain and revitalize their organizations while restoring joy to primary care practice.

Reach

- Goal for Number of Primary Care Practices Recruited: 255-300
- Goal for Number of Primary Care Professionals Reached: 765-900
- Goal for Population Reached: 1.15-1.35 million



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Comment from Principal Investigator

Anton Kuzel, M.D., M.H.P.E.

“This AHRQ initiative is crucial for ensuring that primary care practices are delivering optimal care because they have adopted best practices. In Virginia, we will work to restore the joy of practice for hundreds of primary care offices. This is essential if we aspire to achieve the Triple Aim for population health care.”

Notable Project Features

- Extension of an existing State-supported primary care transformation initiative
- Use of motivational speakers and peer support to generate physician interest in restoring joy to the practice of medicine
- Focus on a mix of urban and rural populations

Approach and Methods

Practice Recruitment and Enrollment

Primary recruitment targets are small- to medium-sized practices that have electronic health records systems. During the first 6 months of the project, the Cooperative will recruit practices by:

- Using existing Cooperative member communication networks (email, newsletters, Web sites, meetings) and leveraging existing relationships with targeted practices.
- Establishing a communications hub on the Cooperative’s Web site with a dedicated recruitment page.

Support Strategy

The Cooperative will offer practice facilitation in an intensive intervention and coaching phase (4 months) followed by a maintenance phase (4-20 months), and will have the following components:

- *Expert consultation* to help practices solve specific challenges in quality improvement and practice transformation.
- *Collaborative learning events* to help practices learn and implement patient-centered outcomes research findings and related practice improvements.

- An *online support center* where practices can find and share announcements, ideas, insights, and promising practices. Online resources will include articles, tools, tutorials, and Webinars, plus data on community CVD indicators.
- *Data feedback and benchmarking.* Practices will report on multiple dimensions of their experience, including ABCS measures, which will allow them to compare their performance to other practices and will inform their practice improvement efforts.

Evaluation

The Cooperative will use a stepped-wedge design, with practices stratified by geographic region and then randomized to a specific wedge and intervention start date.

Strategies for Disseminating Study Findings and Lessons Learned

The Cooperative will disseminate findings through quarterly reports, three national Webinars, three issue briefs with national distribution, and outreach to partners and State and national stakeholders.

¹ <http://www.vahealthinnovation.org/scorecard>. Accessed April 26, 2015.

² <http://atlasva.org>. Accessed April 26, 2015.

³ *Virginia Health Equity Report, 2012. Richmond (VA): Virginia Department of Health; 2012.* <http://www.vdh.virginia.gov/OMHHE/Documents/Health%20Equity%20Report.pdf>. Accessed April 26, 2015.

⁴ <http://nhqrmet.ahrq.gov/inhqrdr/reports/nhdr>. Accessed April 26, 2015.