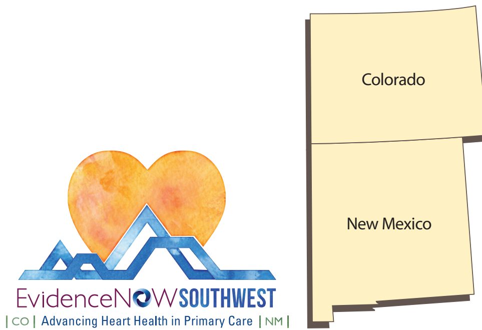
EvidenceNOW
Advancing Heart Health in Primary Care

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 established seven regional cooperatives composed of public and private health partnerships that 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:

EvidenceNow Southwest

practiceinnovationco.org/ensw

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 7.5 million people. The States are racially and ethnically diverse, with substantial Hispanic (Colorado: 21.3 percent; New Mexico: 48.5 percent) and Native American (Colorado: 1.6 percent; New Mexico: 10.6 percent) 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,[2] 25 to 30 percent have high blood pressure, 6 to 7 percent have diabetes,[3] nearly 60 percent are overweight or obese,[4,5] and about 30 percent have high cholesterol levels.[6]

Specific Aims

1. Build primary care practice capacity for quality improvement, change management, and implementation of patient-centered outcomes research (PCOR) 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 (i.e., standard versus enhanced intervention with patient engagement activities) to improve cardiovascular risk in primary care patients.
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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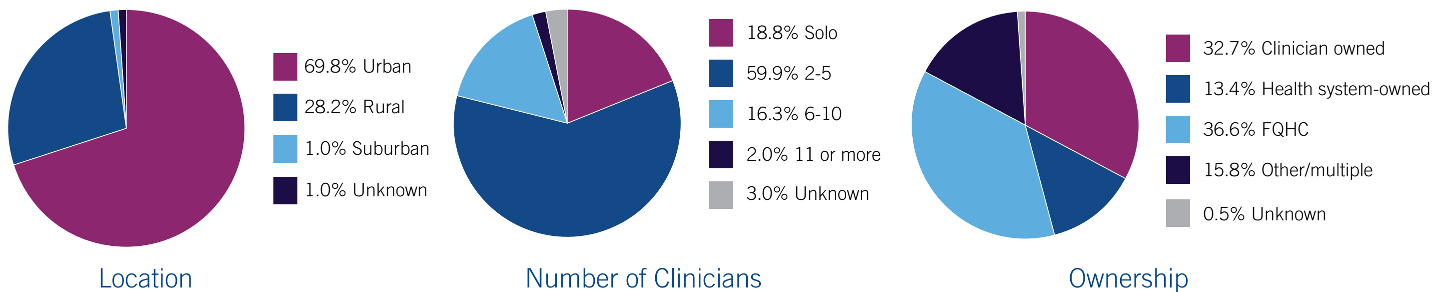
Reach: Number of Participating Practices: **202**



Note: These preliminary data are provided for illustrative purposes. Numbers are subject to change based on final data analyses. Data courtesy of ESCALATES, the EvidenceNOW independent national evaluator under AHRQ grant number R01HS023940-01. For more information about the national evaluation, visit: www.escalates.org

Updates on Key Project Components

Support Strategy

Each participating practice receives 9 months of support consisting of:

- *A practice transformation support team:* practice facilitator, clinical health information technology advisor (CHITA), and a regional health connector (RHC) in Colorado or health extension rural officer (HERO) in New Mexico.
- *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* and a CVD toolkit

Practices randomized to an enhanced intervention group also receive an enhanced practice transformation intervention consisting of optional patient engagement activities and resources such as:

- *Materials developed through the "Boot Camp Translation" process* in which practices, patients, and the community collaborate to translate best practices into culturally and community-relevant materials
- Additional coaching to incorporate patient engagement activities into practice transformation efforts, including the use of *patient and family advisory councils* and other activities, to ensure that practices' quality improvement efforts are both transformational and patient-centered

Update

The Southwest Cooperative recruited a total of 234 practices, of which 211 submitted practice surveys and had an initial kickoff meeting with the practice facilitator. Of those, 202 remain active—148 in Colorado and 52 in New Mexico. The practices represent a mix of small solo or group practices, community health centers, and nearly a third are multispecialty practices. Together they serve a population of which more than one-fourth of patients have Medicaid coverage, and another 11 percent have no insurance at all.

The team of practice facilitators, CHITAs, and RHC/HEROs support participating primary care practices with practice transformation and technical support to document, report, and analyze measures to improve the quality of care at their practices.

At baseline, a bit more than half reported their EHRs had prompts for chronic condition monitoring or prevention. Less than a third used standing orders for chronic condition monitoring or prevention. On the plus side, more than 60 percent used one or more registries to track certain conditions within their patient panel, which shows a level of familiarity with population health concepts.

As of June 2017, 190 practices had reported at least one ABCS measure. However, some practices required chart reviews because the data could not be pulled automatically from the EHRs. Most reports required data quality checks and cleaning to ensure accurate data.

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Evaluation

The Cooperative is using a two-arm, cluster-randomized trial with an external matched cohort control group to assess the impact of the standard patient engagement and enhanced practice transformation interventions. Practices are randomized at the county level within New Mexico and Colorado. The qualitative data collection efforts are robust and involve practice facilitator field notes, a quarterly intervention tracking form, and qualitative interviews with a small number of practices in both Colorado and New Mexico. In Colorado, the Cooperative team is also coordinating EvidenceNOW activities with other initiatives, such as the State Innovation Model grant (SIM) and the Transforming Clinical Practice Initiative (TCPI).

Update

The Southwest Cooperative have completed the collection of baseline practice and practice member survey data and is currently conducting analyses for baseline and early findings manuscripts. These include:

- a report on baseline practice characteristics associated with capacity for patient-team partnerships
- a paper examining practice characteristics associated with initiation of successful ABCS reporting
- a paper on practice facilitation

Several other manuscripts are in progress or in the planning phase.

Nine- and 15-month survey data collection as well as ABCS measure submissions from the practices are progressing on schedule. Chart audits are underway for practices that have completed the full 15-month study period but are unable to produce all ABCS measures.

Comment from Principal Investigator

"EvidenceNOW has provided a tremendous opportunity for our region to improve cardiovascular health care, to support practices in adopting new models of advanced primary care, and to build a workforce to align and coordinate efforts to improve both individual and population health. The partnership between New Mexico and Colorado has allowed us to build on the experience and expertise across our two States in a way that would not have otherwise been possible. The new frameworks, competencies, and partnerships developed as a result of this work can greatly benefit our region in the future."

Perry Dickinson, M.D.

Publications and Other Dissemination Activities

The Southwest Cooperative has published one article and one blog post and has made presentations at several national conferences.

Publications:

- Health Extension and Clinical and Translational Science: An Innovative Strategy for Community Engagement [Journal of the American Board of Family Medicine, 2017]

Blog post:

- Health Affairs blog: http://healthaffairs.org/blog/2017/07/25/diffusion-of-community-health-workers-within-medicaid-managed-care-a-strategy-to-address-social-determinants-of-health/

Presentations:

- Collective Efforts to Overcome Quality Measurement Challenges: Lessons from a Primary Care Learning Community [Academy Health, 2017]
- Patient-Practice-Public Health Partnerships for Primary Care Practice Improvement in Cardiovascular Health: results from four Boot Camp Translations for EvidenceNOW Southwest [PBRN, 2017]
- Practice Detailing by Health Extension Regional Officers (HEROs) Plus Clinically Relevant Workshops Stimulate Provider Behavior Change in Managing Chronic Pain [NARCAD, 2017]
- Practice Detailing by Health Extension Regional Officers (HEROs) Plus Clinically Relevant Workshops Stimulate Provider Behavior Change in Managing Chronic Pain [NAPCRG, 2017]
- Study Design Challenges and Solutions for Implementing the EvidenceNOW Southwest Trial to Improve Cardiovascular Health [NAPCRG, 2017]
- Using Electronic Clinical Quality Measures Data to Improve Primary Care Practice: Early Learning from AHRQ's EvidenceNOW Initiative [STFM Conference on Practice Improvement, 2017]
- A Training and Support Curriculum for Engaging Patients as Partners Across Ambulatory Primary Care Practices [PBRN, 2016]
- Adaptive Continuing Professional Development (CPD) for Rural Providers: A new Longitudinal Model [The World Congress on Continuing Professional Development: Advancing Learning and Care in the Health Professions, 2016]

- Influences of the Electronic Health Record System on Practice Improvement in a Primary Care Initiative to Improve Cardiovascular Health [NAPCRG, 2016]
- Primary Care, Health Extension, and the Social Determinants of Health [The Robt Graham Center's Starfield Primary Care Summit: Advancing Primary Care Research, Policy and the Triple Aim, 2016]
- Role of Primary Care Practices in Improving Community Health [Annual Family Medicine Weekend, U of Oregon Health Services Center, 2016]

[1] https://www.census.gov/quickfacts/fact/table/NM,CO. Accessed August 18, 2017.

[2] https://www.cdc.gov/nchs/data/dvs/lcwk9_2014.pdf Accessed August 22, 2017

[3] http://healthyamericans.org/states Accessed August 22, 2017

[4] https://www.cdc.gov/obesity/stateprograms/fundedstates/pdf/new-mexico-state-profile.pdf Accessed August 22, 2017

[5] http://www.chd.dphe.state.co.us/Weight/obesity-in-Colorado-infographic.html Accessed August 22, 2017

[6] http://www.statemaster.com/graph/hea_hig_cho-health-high-cholesterol Accessed August 22, 2017

Last updated date: November 2017